

Mount Saint Vincent University

Social class in medical school: Teaching and learning in the formal curriculum

by
Terrilyn Chiasson
Halifax, Nova Scotia

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Abstract

We know that individuals receive different healthcare depending on their social class (e.g. upper, middle, lower). Formal medical school curricula may not help students to effectively learn about patients from all social backgrounds and circumstances, or how these backgrounds may interact with generic medical treatments. When knowledge or truth about social class is included in any medical school curricula, this knowledge may inadvertently include stereotypes that show certain classes in a negative light, possibly perpetuating inaccurate information to medical students about certain individuals in our society. Given that most medical students are from middle to upper class families, these students may come to medical school with limited knowledge about (and comfort with) social backgrounds that are unlike their own. In addition to learning about the social class of others, students must gain awareness of their own social class, including possible privileges they enjoy that are not accessible to all members of society. Through a Foucauldian-influenced “discourse analysis” of a sample of medical school curriculum at one university, I analyzed what constitutes knowledge and truth about social class in this curriculum and how this knowledge may result in power outcomes as some individuals from certain social classes are depicted as less favourable than others. My analysis will include interviews with second-year medical students as well as reviews of the case studies from the curriculum used by these same students. Formal medical school curricula have an obligation to provide education about medicine that is representative of individuals in our current society, taking into consideration the social determinants of health, to ensure that equality and quality exist in medical education, furthering its integrity as a discipline.

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Chapter One: Introduction

Adult education is centrally about knowledge construction and integration. This construction and integration is strongly influenced by ideology where belief systems, values and philosophies that are legitimized or dominant in society, influence what is included in the classroom as knowledge and truth. Although adult education is a field known for social activism influencing knowledge reform, traditional philosophies may still persist in some fields.

This thesis explores social class content in formal medical undergraduate education and how it is taken up by medical students. This project is motivated by a concern about the importance of equity in health and health care, and a belief that learning about social class can reiterate or challenge social inequities, keeping in mind the higher connection to social ideologies or discourses on social class, to which both students and teachers would be have been exposed and possibly influenced by.

Through a combined interest of both social class and medical school curriculum, I explored discourses of social class that exist in the formal curriculum, using feminist poststructuralist theory, which combines both Feminism and Foucault's work on knowledge creation using language, discourses, and power (Weedon, 1987). Bourdieu's concepts of more micro-society, social class relations and habitus will be incorporated to provide a well-rounded picture of how knowledge and power operate at all levels in society, and on a higher level, represent the dominant social ideology of social class.

Language and Knowledge Creation

What we know to be true about ourselves and our social surroundings, as well as what happens as a result of our actions, "comes to be" through language. This "knowing" is not static and is dependent on "discourses." Discourse includes verbal conversations, textual/written content, visual representations and ways of acting, all in reference to a particular topic or issue. Discourses have effects that suggest and influence ways of knowing and acting in a society or culture, at a particular point in time (Carabine, 2001). Various discourses come together in what Michel Foucault termed a "discursive field," where a relationship exists between language, social organizations, and individuals, and is also where oppressive power exists, is used and resisted, in the creation of meaning and truth (Weedon, 1987, p. 35). Positioning knowledge as something that is fluid allows it to interrupt that which is considered to be the truth or normal, allowing inclusion of a variety of knowledges, from a variety of groups or individuals in society. In this research, language, knowledge and truth about social class, within a particular curriculum, will be explored.

Knowledge, Language, and Truth on Social Class

Notable social class theorist, Pierre Bourdieu (1985) describes social classes as: "Sets of agents who occupy similar positions and who, being placed in similar conditions and

subjected to similar conditionings, have every likelihood of having similar dispositions and interests and therefore of producing similar practices and adopting similar stances” (p. 725).

According to the definition above, an agent's, or individual's, socialization (positions, conditions and conditionings) contributes to the individual's practices or stances, which Bourdieu refers to as “habitus.” Groups of individuals become similar in both their histories of socialization, as well as in their current actions and values. For example, individuals may belong to the same social class as other individuals with similar conditions, such as income, wealth, occupations, and housing situations, as well as similar conditionings, such as tastes, behaviours, and values. These social groupings or classes do not just happen and an individual is included in a particular social class by both outer (e.g., other individuals, governments) and inner (self-categorizing) forces. It is therefore not only others that designate an individual to a social class, but the individual also may self-assign themselves to a social class based on socialization, experience and “fit” or habitus (Hannus & Simola, 2010).

Social Class and Power to Act in Society

The relationships between individuals within certain social classes can result in access to current or potential resources, which Bourdieu terms “social capital” (Bourdieu, 1986). As a result, some social classes have greater access to socially-valued resources, which can lead to inequities between the various social class groups, where certain resources (e.g., vocational title, tastes, values) are deemed more favourable than others, possibly giving certain individuals more influence in society (Hannus & Simola, 2010). Another imbalance that may occur between social classes is due to various levels of “symbolic profits,” which are benefits that are gained by individuals based on affiliation with a particular group. The more privileged the group, the greater the benefits, simply due to being a member (Bourdieu, 1986, p.89).

Foucault discusses an over-arching type of power, that of “governmentality,” where the dominant ideologies of society and societal institutions are reinforced by proxy. For example, health inequities experienced by certain social classes, occur not through direct communication from governing institutions, but from afar through smaller systems, such as curriculum. Bourdieu's discussions of power relations are through his descriptions of “symbolic order” where individuals regulate themselves and others through and among social groups or classes according to particular resources they have access to (Hannus & Simola, 2010). One of the ways that power can be enacted in society is through knowledge development as well as decisions around what information is important to know as a society, either through societal group dynamics (Bourdieu's symbolic order) or through societal institutions (Foucault's governmentality). When one class or institution has more influence over knowledge creation and implementation, inequities may result by invalidating the inclusion of everyone's

contribution to knowledge. Discussions of power and the ways it is enacted in society are very important in the context of knowledge generation and discourses.

Knowledge Generation and Education

Power and knowledge are intricately interconnected. Power relations shape what is known and can be known, and thus can be repressive, with meaning and knowledge benefitting some, but not others. At the same time, when knowledge develops in resistance to power relations it can also be productive (Doering, 1992). Knowledge is sometimes created by a dominant culture's ideology (or ideologies) at a particular time, and in a particular context, such as when a provincial government's Department of Education develops curriculum and chooses particular textbooks and reading books for schools. In this case, only a handful of people decide what is important to be known and by default, what is not important for school children to know. Similarly, a relatively small group of people decide what is to be known in regard to medical education. However, through resistance, via the inclusion of a variety of knowledges, and the evolutionary ability of knowledge in general, we can effect change to what is known (Doering, 1992). This opportunity for knowledges to exist on a dynamic scale is also reiterated through Foucault's poststructuralist analyses that view knowledges as discourses instead of truths (Johnston, 2014).

The possibility that meaning or knowledge can be created and re-created is potentially empowering to individuals, groups of individuals (e.g. social classes) and institutions. Having a part in the (re)creation, (re)interpretation, and (re)invention of meaning, to try to counteract or resist one, historically-accepted knowledge that may not support equity and equality in how individuals are depicted and or treated (English & Mayo, 2012), could lead to a greater balance of power in society. This thesis will focus on overarching concepts involved in knowledge creation in education, such as language, discourse, discursive field, subjectivity, and power, and how they apply to adult education, specifically within a medical school and its discourses on social class in the formal medical curriculum.

Formal Medical Education and Social Class Knowledge

The Committee on Accreditation of Canadian Medical Schools (CACMS) has developed standards for the accreditation of medical education programs in Canada. In order to have status as a medical school, a university must abide by these accreditation standards. CACMS accreditation elements that are relevant to this research study include the standard that program objectives are to be competency-based, which allow for the assessment of the medical student, with one of these competencies being that of cultural competence, which will be discussed at greater length in the next chapter, but for now it is worth noting that CACMS requires that medical curriculum "provides opportunities for medical students to recognize and appropriately address cultural biases in themselves, in others, and in the healthcare delivery system" (CACMS, 2015, p. 15) and goes on to describe how this could be integrated in to the curriculum. In

contrast, CACMS does not include a standard for social competence and only provides the requirement that the “faculty of a medical school ensure that the medical curriculum includes instruction in the diagnosis, prevention, appropriate reporting, and treatment of the medical consequences of common social problems” (CACMS, 2015, p. 15). Social problems are not defined, but this language seems to suggest a causal link between social problems (or inadequacies) and medical issues.

Formal medical school curriculum would ideally provide students with knowledge and awareness of a fair and complete picture of patients, where the social context and situations of the patient are given as much attention as their physical and mental health, and where the student is aware of their own social class and its effect on relationships with others. Social circumstances and social class are an important part of a patient’s story, and can lead to disparities in treatment in a number of social institutions, including healthcare (Taylor, 2003).

Formal medical curricula may influence what students come to value as important and what is considered “truth” in medicine. Most medical students come from middle and upper class backgrounds (Beagan, 2005) and may not have an understanding of their own social class and that of others, as well as how their social class may affect interactions, relationships, and comfort levels with patients. This issue is important because what students learn in formal medical curricula could shape how they relate to and interact with others during their studies and beyond, which could impact social class inequities in healthcare as they may carry this knowledge forward in their careers.

Motivations for this Research Project

I am interested in the language and knowledge or so called truths that exist in medical school formal curricula about social class, as exhibited by the contextual language used. In this research I wanted to learn about how language concerning social class may contribute to power outcomes, and where the resulting knowledge may be interpreted and applied, or resisted by students. As I am also a member of society and subject to existing social class relations, I have a vested interest in this topic. I have always been interested in how people relate to one another in social contexts, especially across a social class spectrum, and why some people feel they fit with some people and not others, and how this results in the pursuit or avoidance of some ‘others.’ I began to identify with my own social class in high school when I, from a working-class background, was bussed to a school with students mostly from middle to upper class families. I was more comfortable with the students who seemed more like me, at the time, in undefinable and sometimes invisible ways. I realize now that this comfort was based on similarities in social class. Social class influences have continued throughout my life, as is true for others, and there have been times when I have not acted ‘right’ or known the ‘right’ people, to move smoothly through middle or upper class settings. But I have also obtained education and occupational privileges because of my social class.

Currently, I am working in a medical school where I have seen first-hand the pressures to fit in and act the same as those from the middle to upper social classes.

For this research, I collected information about discourses on social class content in the medical school formal curriculum, through interviews with students and review of case studies used tutorials. This is an important area of research because possible inaccuracies or stereotypes in the depictions of social class in this curriculum could negatively influence students' understandings of social class, possibly affecting future interactions and relationships with fellow students and eventually patients. Medical education, which teaches students how to care for patients, should offer a balanced curriculum of both biomedical and social content and concepts, as human beings are a combination of both; omitting one or the other could result in an incomplete medical education. My background and work experience definitely influenced my data collection and analysis processes, as my assumptions, interpretations, and judgments are a product of both. Throughout the research I regularly reflected on how I was processing data and analyses, but the resulting interpretation is undeniably affected by my own social locations.

The following chapters detail the theoretical framework used for this research and literature review, research methods used in the thesis research, including ethical concerns, analysis of the data from examination of social class content in the case studies and interviews conducted with students regarding their understandings of social class in the curriculum. These two streams of data collection and analysis come together in the final chapter where I explore the discourses surrounding adult learning on social class in medicine, and their implications for power relations in health care.

Chapter Two: Theory and Literature Review

As discussed in the previous chapter, this research is focused on social class discourses in the formal medical undergraduate curriculum. This research will be viewed, analyzed and discussed using the theoretical framework of feminist poststructuralism.

Through a feminist poststructuralist framework, I seek to explore what is considered to be knowledge on social class in one medical school curriculum, where knowledge is seen as contextual and not an ultimate truth, in addition to being biased, political and oppressive to some members of society. After providing a brief overview of the theoretical approach, literature relevant to this research and complementary to the methodological framework will be discussed encompassing the many elements of learning situations, including how adults learn, how learning is disseminated in the classroom and what is delivered as knowledge through the specific content that is chosen, in particular how medical curriculum is structured, how it delivers knowledge and what is deemed necessary to know.

Theoretical Framework: Feminist Poststructuralism

Dominant discourses and knowledge have an impact on education on social class in the formal medical curriculum. I used a framework in this research to discuss how power in dominant discourses can potentially silence some discourses while empowering others as legitimate knowledge on social class.

Feminist Theory

Feminist theory has come a long way since the suffrage movement, which arguably only benefited middle-class white women, and is now considered the first wave of feminism. Second wave feminism is referred to by Naomi Wolf as “victim feminism,” describing it as women discriminating against other women and feelings of “self-righteousness.” These feminists were more into rebelling against societal constraints of women’s sexuality and beauty, instead of diversifying or expanding characterizations (Wolf, as cited by Snyder, 2008, p. 179). Third wave feminism doesn't seek to unify women under one definition, but is comfortable supporting women with various, intersecting identities (Snyder, 2008). Current feminist theory is also aligned with intersectionality, which is mostly concerned with including poor women and women of colour into “White, Western feminist theory (Davis, 2008, p. 71). This theory also sheds light on how women experience compounded discrimination and oppression based on a combination of identities, including race, ethnicity, and class, in addition to gender (Monrouxe, 2015). For this study, feminist theory will be interpreted using third wave feminism inclusivity, with intersectionality considerations.

Poststructuralism and Feminist Theory

Feminists were attracted to poststructuralism because of its ability to contextualize meaning and avoid a single reality (Weeden, as cited in Arslanian-Engoren, 2001). Under poststructuralism, feminism is able to challenge "patriarchal discourse, social institutions, and power relationships that disadvantage and oppress women in contemporary society (Scott, as cited in Arslanian-Engoren, 2001, p. 513). This allows for women to develop their own knowledge and meaning that allows for empowerment and emancipation from marginalizing discourses.

Feminist Poststructuralism Framework

Combining the dynamic inclusivity of women through third wave feminism and intersectionality, with poststructuralism's allowance of a multitude of discourses and knowledges on any given topic, was a great fit for my research on how knowledge on social class is constructed in a sampling of formal medical curriculum.

I used Feminist poststructural theory as the framework for analysing power in the creation and dissemination of knowledge on social class in a portion of medical curriculum. Dominant knowledge contains power to elevate or oppress certain discourses, beginning with language, as "Language is the place where actual and possible forms of social organization and their likely social and political consequences are defined and contested. Yet, it is also the place where our sense of ourselves, our subjectivity, is constructed" (Weedon, 1987, p. 21). As I also rely on the social class theories of Pierre Bourdieu, as a prominent social class theorist, through this thesis, it is important to note that his social class theories and meanings are included are under the context of the power relations that result from being designated into a particular social class, and also by self-designating into social class (Bourdieu, 1987). Bourdieu's theories fit within a feminist poststructural framework because he also recognized the oppressive ability and power in meaning, in his case it was through the delineation of groups of subjects within a social hierarchy (Eick, as cited in Hannus & Simola, 2010).

What we know to be true about ourselves and our social surroundings, as well as what happens as a result of our actions, 'comes to be' through language. This particular way of knowing is not static and is somewhat dependent on the language used to describe and debate knowledge in our everyday lives, through "discourses." Discourses are ways of talking about and constructing a topic, shaping what can be thought and known to be true, acceptable or even thinkable. For the purposes of this research, discourse will include verbal conversations, textual/written content, visual representations and ways of acting, all in reference to a particular topic or issue. Discourses have effects that suggest and influence ways of knowing and acting in a society or culture, at a particular point in time (Carabine, 2001).

Various discourses come together as Weedon (1987) describes in Foucault's "discursive field," where relationships exist among language, social organizations, and

individuals. This is where power is constructed, is used and resisted, in the creation of meaning and truth (Weedon, 1987, p. 35). Though dominant discourses are those that circulate through authoritative sources and institutions, there are also always alternative discourses circulating. Positioning knowledge as something that is fluid allows it to interrupt that which is considered to be “the truth” or “normal,” allowing inclusion of a variety of knowledges, from a variety of groups or individuals in society. For the purposes of this research, the language, knowledge and truths about social class were examined using a framework of feminist poststructuralism, where the power of the knowledge that is disseminated in medical education may establish normative standards and understandings that prove oppressive to those in lower social classes.

Feminist poststructuralism insists that knowledge and power are inextricably linked. Power and knowledge are intertwined. Power limits what is acceptable to be known, and knowledge develops in response to and sometimes in resistance to the limits set by the power relations. In this way, power has a productive element, as well as a repressive element. (Dickson, 1990 as cited by Doering, 1992, p. 25)

Meaning and knowledge, then, can benefit and privilege some, but not others. Knowledge is circulated through dominant discourses at a particular time, and in a particular context. This may be very top-down authoritative discursive control, such as when a school board develops curriculum and chooses particular textbooks and reading books for schools. In this case, only a handful of people decide what is important to be known and by default, what is not important for school children to know. In contrast, popular definitions of healthy lifestyles may circulate through school classrooms, popular magazines, cooking shows, guidelines endorsed by agencies like the Heart & Stroke Foundation, as well as in casual conversations among friends and strangers. As will be discussed in the literature review following, power is activated in curricula through discourses reinscribed in medical education, which may privilege certain knowledge and information over others. However, the availability of alternate discourses enables resistance, via the inclusion of a variety of knowledges, and the evolutionary ability of knowledge in general, which can effect change to what is “known” (Doering, 1992; Johnston, 2014).

The possibility that meaning and knowledge can be created and re-created is potentially empowering to individuals, groups of individuals (such as social classes, or students) and institutions giving them privilege over others, but also allowing for resistance discourses. As Foucault states, “where there is power, there is resistance,” because resistance can counteract the power of normalized or dominant language (Mayo, 2000, p. 103). These resistance discourses can begin to chip away at normalized knowledge and give voice to discourses that may be important, yet ignored, in education.

Governmentality

The way discourses govern a populace operates through a process Foucault called governmentality. Dominant discourses and knowledges permeate society, including education, establishing normalized standards to which people are expected to aspire or adhere, through governing their own actions, thoughts, and interactions. “Individuals are governed by the ideological state apparatuses in the interests of the ruling class” (Weeden, 1987, p. 30). Educational institutions are influenced through dominant constructions of what can be known and what is important to know as demonstrated through curricula. For example, as I explain later, understandings of health that arise from upper and middle class experiences, knowledges and values begin to circulate more widely through the media, and through education, beginning from the top with government policies’ focus on individual lifestyle and lifestyle change in terms of health (Alvaro, Jackson, Kirk, McHugh, Hughes, Chircop & Lyons, 2010). Bourdieu’s symbolic order also frames societal power relations, but in the context of this thesis with its focus on curriculum discourses, Foucault’s governmentality is more relevant. Power in curriculum through the selection of knowledge is considered here to be more of an institutional power, although it could be argued, on a more micro level, social class would be a factor. This level of analysis is outside the boundaries of this research study.

In neoliberal forms of governance, individuals and institutions maintain discourses of power, with formal forms of government, and the use of force or coercion, seemingly at a distance (Hannus & Simola, 2010). Governmentality is described by Michel Foucault as the “conduct of conduct” where individuals act out or resist normalized standards and expectations as proscribed, and prescribed, by governing forces, which are able to govern at a distance, trying to influence subjects into fulfilling the wishes of society (Ettlinger, 2011). These processes of self-governance and governance of others are subtle and not always conscious, as individuals rely on dominant discourses to establish how they should act. Governmentality guides institutional processes such as a medical school curricula through mechanisms that are subconsciously enacted through the “subjects,” such as school directors, curriculum planners, case writers, and medical students, to help promote the ideologies of larger governing forces (e.g., neo-liberalism) (Stickney, 2011).

Subjectivity and Agency

Discourses and language do not exist in a vacuum outside of human interaction. According to feminist poststructuralism, an individual develops a sense of self, or identity, through discourses, with a sense of their place in the world, their subject position. Discourses construct particular subject positions, positions of agency and identity made available through the knowledges and actions possible within that discourse. For example, discourse about good conduct in education might construct a particular ‘good student’ subject position that entails certain behavioural expectations, such as being on time, neatness in appearance and in written work, attentiveness, responding to adults and so on.

An individual may be left managing conflicting discourses if the subject positions they take up conflict with external discourses or with each other (Weedon, 1987). In education, as will be discussed in the next section, if curriculum content challenges an individual's identity or place in the world, they may resist learning new information. As individuals, or subjects, we develop a sense of who we are and others develop a sense of who we are through "subjectification" (Mayo, 2000 as cited by Hodgson & Standish, 2009, p. 314). How we see ourselves and how others see us may not be aligned and how others see us or subjectify us may affect how we access certain resources in society, such as healthcare. In the case of patients from lower social classes, the ways they are positioned as subjects in curriculum – such as non-compliant, or making poor lifestyle choices – may affect how they are cared for or managed in the system (Mayo, 2000). It can be a frustrating dilemma to be treated in a certain way and not understand why, especially when it may affect one's agency in a situation.

In most education research, the subject takes a main focus with its identity defined by social and cultural contexts, and is considered to be the "site of rights, justice, voice, and identity" (Hodgson & Standish, 2009, p.314). According to Foucault, individuals' actions in following normative standards "produce the effect of power" (Hodgson & Standish, 2009, p. 315). Therefore, power in language and education does not exist on its own and requires individuals and groups of individuals to create or reiterate this power through their agency, as guided by norms through governmentality.

Summary of Framework

This thesis focuses on the power structures involved in knowledge creation and meaning through language, discourse, and subjectivity, in the construction of meaning around social class in a medical school curriculum.

Review of the Literature

The following review of the literature examines three major themes related to education: how adults learn, how education is delivered to the learner, and what is the education or knowledge that is delivered. It then turns to medical education as a particular form of adult learning, attending to the curricular structures and goals as well as how content regarding social class may be approached.

Adult Education

Adult learners

Since the 1920s, scholars and education practitioners have been preoccupied with how adults learn. In 1968, Malcolm Knowles developed guiding assumptions regarding how adults learn uniquely from children, suggesting that adult learners are self-directed, they bring a multitude of life experiences and previous knowledge to the learning situation,

and they prefer learning that is directly applicable to their social circumstances (Merriam, 2001).

Ambrose, Bridges, DiPietro, Lovett, and Norman (2010) describe seven principles of learning, which reiterate Knowles' assumptions, but expand on students' prior knowledge as something that can enhance or create barriers to learning. Course content that complements a student's prior knowledge greatly enhances that student's potential for learning, with the opposite being also true: course content that challenges or contradicts a student's prior knowledge could create a barrier to learning as the student resists the new knowledge or it could make learning much more difficult, as the student would have to first let the prior knowledge go. Letting prior knowledge go may be very difficult as this knowledge may be tied to the student's identity. Bracher (2006) stresses that support for one's identity may be the most significant motivation to learn, where identity is seen to include one's affiliation with groups in society, for example: social class, gender, race, and ethnicity. The chance to enact one's identity, be recognized and supported may be the strongest reasons students have for putting effort into learning course content. When student identity is not supported in course content, the necessity to keep one's identity intact may create a barrier to learning where content may contradict how one identifies with groups in society (Bracher, 2006). For example, if course content included negative stereotypes about women, those students who identified as women might be less motivated to learn the course content. In addition, students need to see course content as relevant and believe they can be successful in the course, in order to feel motivated to learn (Ambrose, Bridges, DiPietro, Lovett, and Norman, 2010).

In terms of the application of knowledge, one of Knowles' assumptions that students need to apply what they learn, Ambrose *et al.* (2010) state, "to develop mastery, students must acquire component skills, practice integrating them, and know when to apply what they have learned" (p.5). This is a powerful message regarding the importance of being able to apply knowledge and not only learning theory or even content in a topic or discipline. As will be discussed on the next section, medicine is a highly applied field and knowledge is learned to help with patient care in the patient-physician encounter. Content included in curriculum that can be directly, immediately applied, may hold greater appeal for learners.

Dominant framework of adult education

Technical rationality has been the underlying framework of adult education since the 1920s when there was a change in emphasis on practical knowledge to an "academic discipline of technical competence" (Wilson & Cervero, 1997, p. 89). This framework has been defined by one of its most notable critics, Donald Schön, as "instrumental problem-solving made rigorous by the application of scientific theory and technique" (Schon, 1983, as cited in Wilson & Cervero, 1997, p. 88). Others have suggested that through this approach, "knowledge-generation is reduced to methodologic issues of techniques" (Dickson, 1990, p. 15). As an example, Dickson (1990) investigated how menopausal women in Western society are reduced to reproductive organs and hormones and complementing negative societal stereotypes, in both health education

and societal discourses, as the result of the predominance of knowledge that focuses on scientific (and medical) technical rational or empirical methods to discuss women according to their biological processes at a particular time in their lives.

Jurgen Habermas, a renowned theorist in the critical development of knowledge, criticized the sole use of technical rationality in the assessment of knowledge (Ewert, 1991). Technical rationality places the focus on “measurable skills” and positions education as a “technical undertaking” (Gallagher, 2005, p. 139). Technical rationality guides how we learn, what we learn, and how we evaluate that we have learned through skills acquisition, according to a set blueprint that must be followed, and does support learning through experience or practice (Gallagher, 2005). This model for education supports a hands-on type of approach to learning where content needs to be packaged in a way that can be applied, which would also reinforce the above notion that the adult learner prefers to learn content that can be used outside of the classroom. As will be discussed below, current education in medical schools seems to employ a new iteration of a technical rational framework through Competency-Based Medical Education.

What is knowledge?

Up to this point, discussion has focused on how adults learn and how education is framed. This section will focus on content, or knowledge, that is disseminated in the education process. Adult education content is greatly influenced by societal discourses on related topics. It is not surprising that content promoted in adult education represents the society in which it is situated (Manglitz, 2003; Kopecky, 2011; Nesbit, 2005), and in our society neoliberal individualism as well as values and discourses of White culture would be extremely influential in what knowledge is considered legitimate and worth knowing (Akena, 2012).

From a feminist poststructural perspective, oppressive power is inherent when a sole discourse, or single answer, is presented in education as knowledge or fact. Discourses that are not included as facts are not deemed relevant and are relegated to the sidelines, either marginalized as other or resistant knowledge, or ignored altogether (Doering, 1992). When the same single-answer knowledge is regularly promoted, normalization of knowledge occurs and contributes to a powerful hierarchy of knowledges on a given topic, also referred to as hegemony. Hegemony in education prioritizes one discourse and marginalizes or oppresses all others, for example teachings of Columbus discovering America. This one dominant discourse is presented as factual knowledge, and can privilege individuals or groups affiliated with this single knowledge discourse (Nesbit, 2005). This normalization of knowledge promotes what is normal through discourses and any alternative would be abnormal or not right (Triantafillou, 2004). When there is a normalized knowledge, the implication is that other knowledges are wrong or abnormal, rather than understanding discourses and multiple, varied and competing.

Knowledge that is normalized in adult education is related to dominant discourses occurring in the current society. Through Foucault’s mechanism of governmentality,

educational institutions and individuals reiterate these dominant societal discourses, which can stress the expectation of “self-optimization” as well as taking responsibility for problems in society (Kopecky, 2011; Nesbit 2005). Rudman (2013) refers to the widespread expectation that people will take individual responsibility for broad societal failings as “individualizing the social”, which she posits is a dominant characteristic of neoliberal discourses. Adult education is very focused on self-improvement and also includes many courses on how individuals can be more responsible citizens, for example by maintaining their own health and that of their families. However, the normalizing effects of promoting a single discourse can be challenged, or resisted, through the acknowledgement of alternate discourses, but this resistance may depend on people’s ability to access and engage with such discourses (Stickney, 2011).

Layers of learning

How adults learn, how education is presented through a specific framework, and what content is delivered as knowledge in the classroom come together in the learning situation. The dynamic elements brought to the classroom by the learner (prior learning, identity, and motivation to learn) may readily blend with or oppose knowledge content and context, in addition to another layer of education where learners socialize with, and learn from, each other. All of these elements may affect what a student takes away from the classroom, in terms of learning.

Evaluation attempts to assess whether student learning matches learning outcomes as established when the curriculum was developed to decide if the curriculum was successful and that the desired learning took place. Yet what is taught may not be precisely what was intended; similarly, what is learned may not be precisely what was taught. Prideaux (2003) identifies three levels of curriculum: “the planned curriculum, the delivered curriculum, and the experienced curriculum” (p. 326). The planned curriculum as developed by administrative bodies, the delivered curriculum as disseminated in the classroom, and the experienced curriculum is what the students actually learn, given how they interpret and understand the lessons, possibly based on their prior knowledge and experiences, identities and motivations to learn.

This section discussed the variety of ‘pieces’ that come together to make up the puzzle of adult education. Of particular interest in this study, in terms of formal medical education, is who are the adult learners in medical education, what constitutes knowledge about social class, and how is education about social class planned, delivered, and experienced by learners?

Medical Education

Medical students: Identities, prior knowledge, motivations to learn

The socioeconomic status (SES) typical of medical students is much higher than that of the general population and does not represent the diversity of Canadians (Dhalla, 2002; Young et al., 2012). Students who do not come from high SES backgrounds may feel marginalized in medical school (Beagan, 2005). While identity congruence or conflict affects motivation to learn, as discussed by Bracher (2006), it may also affect who is motivated to apply to medical school, who may perceive they will fit in with the

environment or potential classmates, and eventually within the profession (Mathers & Parry, 2009; Greenhalgh, Seyan, & Boynton, 2004). Students in medicine and other health professions who do come from lower class backgrounds may attempt to portray themselves as middle or upper middle class, with a possible discomfort of being found out by classmates, or feeling like a fraud (Beagan, 2005; 2007).

Greenhalgh, Seyan and Boynton (2004) suggest a lack of affordability, a privileged admissions process, and lack of mentors in the field of medicine, as possible deterrents to individuals from lower social classes applying to medical school in greater numbers. Young et al. (2012) discuss how admissions requirements may privilege certain individual characteristics having an impact on the nature of who is accepted into medical school and limiting the amount of diversity among students who make it through the admissions process. This, they say, results in a “critical underrepresentation of minorities,” which affects future diversity in the physician population, but also in the medical classroom where students do not encounter diverse life experiences (Young et al., 2012, p.1501). These authors also draw a link between the sociocultural background typical of medical students and physicians, and who they are drawn to care for in their professional careers, which could influence inequities in health care in populations that differ from the demographics wherein physicians reside.

Based on the largely homogeneous social demographics of medical students, they may bring with them fairly limited understanding of matters of social class. Unless they have studied in fields that emphasize social class differences in their undergraduate years, as adult learners their prior learning about social class may be limited to experiences in an upper or middle class environment where social class is often rendered invisible through a discourse of meritocracy (Beagan, 2005; 2007). This prior learning could pose as a barrier when learning about social class in medical school, especially if new content contradicts what they believe about social class and if it negatively impacts their identities, for example through discomfort in learning about aspects of social class that have previously been outside their consciousness.

Competency-Based Medical Education

Currently, medical education follows a framework similar to technical rationality, as discussed above (Gallagher, 2005; Wilson & Cervero, 1997), but using different terminology. Outcomes based medical education (OBME) is the current educational framework used in medical schools in Canada, which focuses on student-led acquisition of abilities in certain areas or ‘competencies’ to prepare students for competency-based residency education (CACMS, 2015). Frank *et al.* (2010) discuss how this competency-based curriculum is based on the acquisition of abilities, or competencies, needed by students to graduate and fulfill the demands of their profession, relying on knowledge that can readily applied in a practical situation. According to these authors, there have been many challenges to and criticisms of this type of curriculum, including extremely narrow definitions of each competency and encouraging meeting milestones over the

pursuit of excellence. Also, it is problematic to study the competencies independently of each other, when these abilities will need to be unified in practice. It is not clear how graduates begin the process of integrating these competencies. Competency-based medical education will be discussed in the following section in terms of one specific competency, that of cultural competency, to discuss how this educational framework addresses social contexts.

Undergraduate medical education in medical schools in Canada are developed in accordance with accreditation standards stipulated by the Committee on Accreditation of Canadian Medical Schools (CACMS). The specific format of study within a medical school is mostly at the discretion of the school provided it follows the accreditation standards of “competency-based program outcomes” (p. 12) where students develop competencies to prepare them for residency programs. Study is to be self-directed and students are expected to undertake an identity as lifelong learner (p. 12). The medical curriculum analyzed for this research project follows a four-year program where the first two years are considered pre-clinical and learning occurs in lectures, labs, and tutorials. The tutorials follow a case-based learning style where students learned together and from each other through the discussion of medical cases, with the goal of reaching conclusions about medical issues discussed. The tutorials are facilitated by a tutor who keeps the discussion moving and possibly provides thought-provoking questions to stimulate discussion in a constructive process.

Cultural Competency & Social Class Content in Medical Education

There is currently no social class competence accreditation requirement for medical schools, but it's possible that medical schools may attempt to address social content through cultural competence, which is an accreditation standard implemented by the Committee on Accreditation of Canadian Medical Schools (CACMS, 2015). CACMS outlines the requirement that curriculum include content regarding how culture impacts health and healthcare inequities (CACMS, 2015). “The goal of cultural competence is to create a health care system and workforce that are capable of delivering the highest quality care to every patient regardless of race, ethnicity, culture, or language proficiency” (Betancourt, Green, Carrillo & Park, 2005, p.499). Cultural competency is considered by many to be a strategy to “improve quality and eliminate racial/ethnic disparities in healthcare” (Betancourt, Green, Carrillo & Park, 2005, p.499), and physicians competent in culture will provide better care. Without a doubt, attention to cultural competency is a step toward paying greater attention to health disparities attributable to social and cultural matters. However, having a competency for either cultural or social class content, may not be the answer to integrating social class into the curriculum.

There have been many criticisms of the cultural competence model where simply learning about ‘Others’ and/or being placed in a different cultural environment does not necessarily assist the provision of better health care. In the case of medical students,

Beagan (2003) found that “teaching social and cultural awareness sometimes promoted ‘othering,’ urging students to see ‘those people’ as having problems, rather than seeing themselves as equally affected by their own class, culture, and social background” (p.610). Wear (2003) states that cultural content shouldn’t solely concentrate on differences that marginalized groups may have from the dominant culture, as these differences may be seen as shortfalls. If students’ cultures were also discussed, possibly in terms of similarities with a multitude of cultures, they might be less inclined to emphasize a separation between themselves and individuals with seemingly different backgrounds. Also, students who are not learning about their own culture may not be aware of the privileges they enjoy due to their place in society, where others may experience inequities because of their skin colour and/or social, economic and cultural characteristics (Cook, Lusk, Miller, Dodier & Salazar, 2015; Niehuis, 2005). McIntosh (1995) defines privilege as “a special right, benefit, or advantage given to a person, not from work or merit, but by reason of race, social position, religion or gender,” which can result in an attitude of entitlement where things are expected (as cited in Liu, Pickett & Ivey, 2007, p. 195). By not understanding privilege, an erroneous assumption may be made that everyone in society experiences parallel systemic advantages.

Cultural competence as an approach to teach social issues

The cultural competence framework has been critiqued for advancing a very narrow definition of culture that collapses “racism, poverty, colonialism, and ethnocentrism into cultural difference” (Beagan, 2015, p.7) while ignoring other types of diversities, such as social class, religion, sexual orientation, gender identity, and physical abilities (Beagan, 2015; Kumas-Tan, Beagan, Loppie, MacLeod & Frank, 2007). An over-simplified definition of culture may also fuse race and ethnicity (Carpenter-Song, Schwallie & Longhofer, 2007) further narrowing what it means to be culturally competent. Kumas-Tan *et al.* (2007) reviewed current cultural competence assessment tools and found that culture was defined in terms of ethnicity and race and also that only ‘others’ are seen to have culture, not physicians. Moreover, “cultural competence is achieved when practitioners acquire sufficient awareness and knowledge of the Other, often through repeated exposure to the Other” (Kumas-Tan *et al.*, 2007, p. 552). These researchers continue by stating that repeated contact with the Other does not say anything about the quality of this contact. Experiences could be either positive or negative and emphasis should also be placed on “depth of understanding” of culture (Kumas-Tan *et al.*, 2007, p.554).

At the same time, culture – whether the culture of an ethnic group or a social class or a linguistic community – is not experienced in the same way by all group members and it is not static and unchanging (Beagan, 2015; Carpenter-Song, Schwallie & Longhofer, 2007), again making it seem difficult or impossible to become adept at culture. There is also a danger of attributing certain behaviours and traits to particular cultures, as this can lead to stereotypes and the physician may overlook health issues or misdiagnose based on stereotypes related to the patient’s social or cultural background (Carpenter-

Song, Schwallie & Longhofer, 2007). Case-studies used to teach medical students may reinforce negative cultural stereotypes, which may lead to harmful or erroneous assumptions about patients (MacLeod, 2011). Also, students may experience difficulty learning about group-specific knowledge when there are differences among individuals (Shapiro, Lie, Gutierrez & Zhuang, 2006). Intersectionality theory discusses how certain individuals have multiple compounding cultural and social circumstances that would make putting them in one cultural category harmful. Personal qualities such as gender, race, and social class, intersect with culture, creating unique lived experiences and possibly add extra challenges for individuals or sub-groups in the same culture (Monrouxe, 2014; Fuetes, Miranda & Abdulrahim, 2012).

Social class is often overlooked in teaching cultural competency, along with other social factors that affect health apart from race and ethnicity (Beagan, 2015). The Association of American Medical Colleges (AAMC) (2005) stresses the need for students to be trained in cultural competence, but mainly as it relates to racial and ethnic disparities in health care, even though its initial definition of culture also includes religious and social groups. Green, Betancourt and Carrillo (2002) discuss how the importance of social factors has been under-represented when discussing cultural competence and that the most significant obstacles to health will be due to social reasons: “The distinction between social characteristics and cultural factors is not always clear cut, but both are directly relevant to patients’ health and medical care” (Green, Betancourt & Carrillo, 2002, p.193) and “social stressors and support networks,” “change of environment,” “life control,” and “literacy” are major topics that should be given more attention in traditional medical teaching (Green *et al.*, 2002, p. 194).

The Association of American Medical Colleges (2005) warns of the risks of positioning cultural competence as an ‘add-on’ to medical curricula:

A cultural competency curriculum cannot be an add-on to the present medical school curriculum. If issues such as culture, professionalism, and ethics are presented separately from other content areas, they risk becoming de-emphasized as fringe elements or of marginal importance (p.2).

Thus, there seems to be a need for a more encompassing way to incorporate content on culture and social class into the formal medical curriculum in a way that promotes understanding and awareness.

Professionalism and the Culture of Medicine

Professionalism in medical education aims to teach students how to become physicians, through an institutional culture consisting of values and requirements for conduct. According to the CanMEDS framework, which guides the professional development of medical residents, professionalism is primarily about a social contract:

Physicians serve an essential role as professionals dedicated to the health and care of others... The Professional Role reflects contemporary society's expectations of physicians, which include clinical competence, a commitment to ongoing professional development, promotion of the public good, adherence to ethical standards, and values such as integrity, honesty, altruism, humility, respect for diversity... Professionalism is the basis of the implicit contract between society and the medical profession, granting the privilege of physician-led regulation with the understanding that physicians are accountable to those served, to society, to their profession, and to themselves. (Frank, Snell & Sherbino, 2015, p. 26)

This definition appears to be a well-rounded 'honour code' of what it means to be a physician, but there is much room for interpretation in implementation. It is entirely possible that enacting professionalism may contradict some other competency expectations. According to Coulchan (2000), many times as medical students progress through medical school a "tacit socialization occurs, transferring sets of values, beliefs, and behaviours that may be altogether inconsistent with the avowed tenets of medical professionalism" (as cited in George, Gonsenhausner & Whitehouse, 2006, p.63.). This socialization occurs partially through the content that is included in the formal medical curriculum, but also through the informal mentoring process that occurs throughout medical studies. This socialization into a culture of medicine and the development of medical professional identities, may be the biggest barriers in learning about and appreciating the social contexts of patients, in order to be accountable to all 'those served' as cited in the above definition.

As discussed in the previous section, cultural competency is normally taught in terms of Others and ethnicities without attention on the culture of becoming a doctor, which includes specialized "language, thought processes, communication, and customs and beliefs that often characterize the profession of medicine" (Boutin-Foster, Foster & Konopasek, 2008, p.108). Taylor discusses the "culture of no culture" of medicine and how medical knowledge is considered truth, instead of cultural knowledge (Taylor, 2003, p. 556). Taylor (2003) continues by saying that it may be difficult to become culturally competent when all the cultural aspects of "the patient's story" are omitted from discussions of the patient, during "clinical narratives" that focus objectively and dispassionately on patients' illnesses and treatments (p. 557). Beagan (2000) states that medical education perpetuates the suppression of cultural biases in students and physicians, in an attempt to improve doctor-patient relationships, but instead of becoming neutral or of no culture, students are unintentionally pressured to become members of the dominant, and invisible, culture. MacLeod (2011) states that there are two competing identities in medical school, that of being professional or being caring, and that these two identities can create a dilemma for the medical student where knowledge around competence is given priority and knowledge around caring is sent to the sidelines. In order to form an identity of competence, which is highly prioritized in

medicine, students may need to favour competence over caring, and knowledge that is mainly biomedical over social.

Boutin-Foster *et al.* (2008) discuss how doctors are socialized and trained to talk using statistics, probabilities, levels of severity, as well as using acronyms and jargon that may be unfamiliar to patients, ultimately creating barriers to communication. Language and discussion are a large part of any medical consultation. In the context of this research, “power is exercised within discourses in the ways in which they constitute and govern individual subjects” (Weedon, 1987, p. 113). As mentioned earlier, students are taught to use particular language when discussing patients (Taylor, 2003). This discourse may create a power dynamic in favour of the physician or medical student where the patient’s reality and knowledge of himself or herself may be dismissed in the face of the objective and authoritative “clinical narrative” used to describe the medical encounter (Taylor, 2003, p. 557). The possibility that medical education emphasizes only one way to describe a medical encounter could enhance a power relation of student over patient, where the patient may have little (authoritative) voice. Physicians may garner power by using language as a way to control their consultations, by leading the patient through the medical encounter in a way that produces a concise, curtailed, clinically relevant narrative (Byrne & Long, 1976 as cited in de Belder, 2012). Physicians are encouraged to “depersonalize” the patient by focusing on their “biological processes” (de Belder, 2012, p. 108).

Power is asserted through the physician’s use of technical medical terminology as well as by dominating the conversation and not allowing the patient a lot of time to speak (de Belder, 2012). Medical education could be a vehicle to change the discourses and use of language in the physician-patient encounter. From a learning perspective, medical students may find it difficult or impossible to integrate competing competence-related training and caring-related training (especially in light of possible prior knowledge that medicine is biomedical information), where competence in medical ability can be something that is achieved and demonstrated, but the ability to navigate social issues is not something that is to be accomplished and is forever in the repertoire of skills (MacLeod, 2011). Students struggle with exuding confidence in uncontrollable patient situations that involve fluid, non-concrete concepts such as class, family status, and life experience (MacLeod, 2011).

It is suggested that as part of becoming “culturally competent” discussion of the medical culture be included in medical students’ education process, to expand the definition of culture, resist packaging culture as something that some patients have, and help students become more self-aware (Boutin-Foster, Foster & Konopasek, 2008). If the culture of medicine does not change, it may be difficult to ever teach about and appreciate patients as whole people with varying social class circumstances.

Social Class Content in Formal Curriculum – Social Determinants of Health

The most significant (if not only) way that social class is appearing in contemporary medical curricula is through discussions of the social determinants of health, a framework that insists health and wellness are not solely due to individual risk factors such as genetics and individual behaviours, but also due to social and economic factors that enhance or hinder health. This approach is not included as a core competency, but is instead taught more removed from real medicine, typically in special courses that specifically include social topics, such as social class, ethics, assisted dying, and advance care planning. For example, at one Canadian medical school Beagan (2003, p. 606) describes a course pseudonymously named “Physicians, Patients & Society” which was intended to address issues of “ethnic, cultural and gender diversity” as well as develop skill in ethics, legal concerns, cross-cultural care, and working with diverse patient populations. Although not specifically focused on social class, social determinants of health allow for conversations of social class to happen in a way that can relate social class to inequities in health care, thereby putting context to social class content. There is not an explicit requirement by the Committee on Accreditation of Canadian Medical Schools (CACMS) for medical curricula to include content on the social determinants of health and only requires “instruction in the diagnosis, appropriate reporting, and treatment of the medical consequences of common societal problems” (p. 15), which makes it seem that social determinants that negatively affect health are problems, possibly adding negative connotation to the person experiencing the societal problem.

Following the World Conference on the Social Determinants of Health in Rio de Janeiro in October 2011, the Rio Political Declaration on Social Determinants of Health was published to document the “determination to achieve social and health equity through action on social determinants of health and well-being by a comprehensive intersectional approach” (World Health Organization, 2011, p. 1). It stated that health inequities arise from the societal conditions in which people are born, grow, live, work, and age, referred to as the social determinants of health (World Health Organization, 2011, p. 2). The Public Health Agency of Canada (2016, no page number) lists specific social determinants of health as “income and social status, social support networks, education, employment/working conditions, social environments, physical environments, personal health practices and coping skills, health child development, gender, and culture”. The College of Family Physicians of Canada (2015, p. 1) includes these and also adds “race, food insecurity, housing, social exclusion, Aboriginal status, and disabilities”. It appears that there is not a generally accepted definition of the social determinants of health. A College of Family Physicians background document on the determinants describes a “social ladder to illness” wherein your position on the ladder would predict your health outcomes (College of Family Physicians of Canada, 2015, p. 1). The determinants work both to enhance health, and to undermine health. Someone with considerable wealth or with food security likely faces better health outcomes, while someone with low income or from a group marginalized by race will likely face negative

implications for health. The "intersectional approach" mentioned earlier would consider that if an individual faced barriers and inequities in multiple social determinants of health, they would be more negatively affected in health outcomes than an individual with one or two negative health determinants.

Chapter Summary

Adult education is heavily influenced by dominant societal discourses in its content, contexts, and frameworks. Students are influenced by these discourses in addition to learning in their educational contexts. In terms of medical education, health inequities can be exacerbated by ineffective education on social class. This chapter reviewed the related literature on how adults learn, the dominant framework of adult education that frames how content is delivered in the classroom. Also discussed is the format of a medical curriculum and how this may affect the delivery of social content, also involving the dynamics of the culture of medicine.

The next chapter will outline how data on the social class content of an undergraduate medical curriculum was collected, followed by two chapters that will analyze both textual content and interview data to compare the delivered and experienced curriculum. The final chapter will present a discussion and conclusion that aims to add context to the data analyses and how this relates to adult learning, in particular what and how medical students learn about social class.

Chapter Three: Methods

The previous chapter outlined how adults learn, with a particular focus on medical students, as well as the format used to frame medical school curriculum. This chapter will describe research methods that were used to collect data on how social class is taught in this particular medical school.

As mentioned previously, I am using feminist poststructuralism to guide this research to uncover discourses of oppressive power operationalized through language and knowledge on social class. Doing poststructuralist discourse analysis requires looking to statements, not for what they say, but for what they do (Graham, 2011). Carabine (2001) defines discourse as “historically variable ways of speaking, writing, and talking about, as well as practices around, an issue. They have outcomes/identifiable effects which specify what is morally, socially, and legally acceptable, or unacceptable, at any given moment in a culture” (p.274). In this thesis I seek to identify discourses that create knowledge on social class in medical education and analyze how power imbalances in this knowledge creation may oppress members of certain social classes, in particular women, through these discourses.

Weeden (1987) discusses discourse analysis as a way to “understand the relationship between language, social institutions, subjectivity, and power” (p. 35) where discourses offer “competing ways of giving meaning to the world and of organizing social institutions and processes” (p.35). Subjectivity refers to the “conscious/unconscious thoughts and emotions of the individual, her sense of self, and her ways of understanding her relation in the world” (p. 32). Discourses establish subject positions which become readily available for individuals to make sense of their lives, their realities, their identities – and those of others: “Individuals are both the site and subjects of discursive struggle for their identity (Weeden, 1987, p. 97).

Social Class

For the purpose of data collection and analysis in this project, social class can be defined as a pervasive classification system in our society, which is dependent on contextual social language used to discuss both this system, and the individuals involved, in the development of truths and knowledge about social class and how individuals and groups of individuals interact in society. The specific language used and the discourses that occur, in certain social contexts, around social class, reflect and reproduce power outcomes and differentials between individuals and social classes.

In his social class theories, Pierre Bourdieu (1985) describes social classes as:

Sets of agents who occupy similar positions and who, being placed in similar conditions and subjected to similar conditionings, have every likelihood of having similar dispositions and interests and therefore of producing similar practices and adopting similar stances (p. 725).

According to this definition, an individual's social positions, conditions, and conditionings contribute to their practices or stances, which Bourdieu refers to as "*habitus*" (Hannus & Simola, 2010, p.4), the internalization of particular class-bound ways of being. Therefore, "sets of agents," or groups of individuals, become similar in both their histories of socialization, as well as their current actions and values. For example, individuals may belong to the same social class as other individuals with similar income, wealth, occupations, and housing situations, developing similar tastes, behaviours, and values. An individual is included in a particular social class both by both how they are identified and categorized by others and how they self-categorized and self-identify. It is therefore not only others that categorize an individual as belonging to a particular social class, but the individual also may self-assign to a social class (Hannus & Simola, 2010). This generic description does not account for the discrimination and marginalization that occurs for some individuals and some social classes due to the language and discourses that become socially dominant or privileged.

The relationships between individuals within certain social classes can result in access to current or potential resources, which Bourdieu terms "social capital" (Bourdieu, 1986, p.88). As a result, some social classes would have great access to resources, including social resources, which can deepen inequities between various social class groups. In the case of health care, inequities may result not only from lack of material resources available to members of lower social classes, but also lack of the "right" social capital, social networks. This is the source of the negative effects on health noted in the framework of the social determinants of health.

Using these understandings of social class, case studies from one Canadian undergraduate medical program were selected and analyzed based on their social class content, as will be described in the following section. Interviews were conducted with second-year students from the same school, to explore their understandings of social class, and their responses to the class discourses encountered in cases.

Document Analysis – Formal Curriculum Materials (Case Studies)

Case-based learning through tutorials is a major part of the undergraduate medical curriculum in the first two years of study at this particular medical school. Students discuss medical case studies in small groups (tutorials) and these cases include an introduction section to introduce the topic, a medical case that incorporates the topic, and discussion questions. Cases are written by at least one faculty member of the medical school and some cases may include writers from outside the medical school who have expert knowledge on the case topic.

Three components of study are included in the second-year medical curriculum (Nephrology, Cardiology, and Respiriology), and one separate socially-focused unit that is scheduled longitudinally alongside the other three units. Analyzing cases from all

three components would have been too much material and data for this research study, thus only cases from Cardiology were used, along with the second-year cases from the Social Focus unit. Cases were scanned for social class content based on Bourdieu-influenced social class criteria: occupation, education, income, hobbies, housing, and tastes, and the language used to describe these criteria in the cases suggested social class hierarchy. Of particular interest is how this hierarchical social class language may have oppressive or emancipatory power results on the subjectivities of the individuals described in the cases, which will be analyzed in the subsequent chapters.

Out of 26 possible cases, 14 case studies were analyzed, seven each from Cardiology and from the Social Focus unit. The analysis included the tutor guides that are provided with each case, which provide possible solutions to discussion questions to guide the tutor. The socially-focused cases would be particularly expected to cover social class, but analysis focuses on how these discourses were constructed. Cases that did not include any details about social class were discarded from analyses (see appendix #1). A form was used to ensure that each case was evaluated using the same criteria (see appendix #2).

Student Interviews

Second-year medical students were recruited via an email from the medical school's main office (see appendix #3). As this method only resulted in three volunteers, the same recruitment message was posted on the Facebook page (see appendix #4) for that graduating year, which resulted in three more volunteers, for a total of six interviewees. All six students had just finished their second year of medical school and had used the case studies that were analyzed for this study in their tutorials.

The interview questions were open-ended so as to explore what the students had learned about social class from the curriculum, including the curricular materials (case studies). Interviews lasted on average 30 minutes, which is relatively brief for open-ended interviewing. The interview question guide is located in Appendix #5.

Interviews were digitally audio-recorded and then transcribed verbatim by this researcher and transcripts were read and re-read, repeatedly. I was interested in noting language used to discuss social class that may privilege or oppress certain individuals, through collation of participants' personal interpretation and reports on what they learned about social class in their formal medical study. Consistencies in discourses in both personal interpretations and reports on the curriculum helped formulate theory on how social class content may exist in formal medical curriculum, potentially to the detriment of certain individuals in society.

Ethics, Confidentiality and Risks

Both Research Ethics Boards for Mount Saint Vincent University and Dalhousie University reviewed and approved the research protocol for this project (see appendix #6 and appendix #7).

For the student interviews, a consent form was discussed and signed before proceeding with interviews (see appendix #8), to inform students that they could quit at any time, or refuse to answer any question, and that their personal identifying information would be kept confidential. They were promised that interview elements to be used in future publication would be disseminated in an anonymous format so that students could not be identified by their comments. The biggest risk of the study was to privacy, given medical students are typically close-knit cohorts. Interviews were identified only by ID number to reduce the possibility of being able to trace individuals and discern identities.

Audio files were erased after they were transcribed, and the only file linking transcripts with actual names was stored in a separate electronic file. Transcripts are stored on a password-protected computer until acceptance of this thesis, or future publication, at which time all copies of data will be destroyed.

Summary

Discourses on social class from case studies and student interviews were analyzed using feminist poststructural analysis to identify how social class is discussed in a sample of a medical curriculum, in addition to language used and how this language might operationalize power regarding social class groups. The next chapter contains the analysis of the formal cases, followed by a chapter detailing the results of the interview data analysis.

Chapter Four: Data Analysis – Case Studies

The following is an analysis of *delivered* curriculum using case studies from the formal medical curriculum, to be followed by a discussion of *experienced* curriculum as described through interviews of medical students, as discussed in the literature review, and how the two may reflect one another (Prideaux, 2003). The first part of this chapter will focus on describing and comparing the two types of cases that were analyzed for the purpose of bringing attention to non-discourse elements or formatting that actually delivers the textual content, where non-language based characteristics may also have power outcomes. The second half of this chapter will focus on the textual content of the cases through poststructural analysis to show how social class is contained in the curriculum through the language used combining into discourses to give social class meaning in this context.

Descriptive Analysis of Cases

As mentioned in the previous chapter, two types of case studies were analyzed for this study: Cardiology and Social Focus (a pseudonym for the course). These case studies are both used to guide tutor-led, small-group discussions, as part of the formal medical curriculum. However, there are differences in content-related and non-content related characteristics of these two types of cases, which could impact how this curriculum is experienced by students.

Case structure and curriculum related characteristics

There are two versions of every case (both Social Focus and Cardiology): one version is developed for the students and one version for the tutor, named the Tutor Guide. The Tutor Guides include extra information on each weekly topic and provide suggested answers to discussion questions that follow every case – the same discussion questions are included in both the student and tutor versions and these questions may differ greatly from one case to another and from one type of case to another. The students do not have access to the tutor guides or the additional information that is provided in the guides and it is up to the discretion of the tutor what additional information they will use during the tutorial.

One of the most significant differences between these two types cases has to do with the amount of time allotted each type in the formal curriculum where double the amount of time per week is spent on Cardiology cases, compared to the Social Focus type of cases. Another significant difference is the amount of content that each type of case includes, varies where the Cardiology cases are, on average, 5 pages for the student version and 11 pages for the tutor guide, resulting in 55% percent more information being available for the tutors, in the guides. The Social Focus unit is not so easily quantified, as one case spans two weeks and, in a separate instance, two cases are discussed during the same week. Based on week and topic, the average student

version is 9 pages and tutor guide is 14 pages, resulting in 36% more information provided for the tutor. Having more time spent on less content, as is the case for the Cardiology cases, would make these cases more favourable to the students. Also, giving double the time to the Cardiology cases in the formal curriculum would appear that these types of cases are more valued by the institution.

The type of authors who write the cases also elevates the Cardiology cases above the Social Focus cases. All cases analyzed were written primarily by University's Medical School faculty members. Social Focus cases may also include writers outside of the University, who have expertise on the topic, as the faculty members are not necessarily experts. For example, the case focusing on Aboriginal health, includes writers who are staff members of First Nations and Inuit Health, Health Canada (Atlantic). Cardiologists are the primary authors of all Cardiology unit cases. Two of these cases also include non-cardiology, Medical School faculty member co-writers (Pharmacology, Geriatrics), as they are experts on non-cardiology content included. Therefore, expert clinicians/cardiologists are the primary authors of the cardiology cases and there are no clinician writers of the Social Focus cases. With no medical doctors writing the Social Focus cases, these cases may seem less medical than the Cardiology cases.

Professionalism and consistency are major themes in the medical profession and therefore would be important in medical school. Case names used for Cardiology cases have a consistent naming pattern of patient name and medical condition, for example: Henry: A Case of Aortic Regurgitation; Mr. M.V.: A Case of Mitral Regurgitation; Sarah Fowler: A Case of Syncope. But, there is not a consistent naming formula for the Social Focus cases: Cultural Competency, week 1: Mr. John and Ms. Claire; Cultural Competency II: Immigrant and Refugee Health; Organ Donation and Transplantation: Jerry, Josephine, and Josiah – Making Difficult Decisions. The lack of consistency or standardization in naming of the Social Focus cases may make them seem less professional than the Cardiology cases and not what one might expect of a formal curriculum at a medical school.

The above discussion summarizes the structural differences between these two types of cases, which may lead students to prefer the Cardiology cases, as well as seeing them as more medical and professional due to more time dedicated in the curriculum, inclusion of expert, clinical writers, and standardized naming scheme. The following section discusses content-related case characteristics that may affect students' learning experiences.

Content focus and language

The content focus of the cases and the language used to deliver this content differs between the Cardiology and Social Focus cases, with one major overall effect being the construction of different persona for health professionals and patients. This may present a conflicting education of how a student believes they should 'be' as a health

professional and how patients should 'be.' Compared to Social Focus cases, Cardiology cases include less detail about the health practitioner and patient, leaving more space for assumptions to be made, and use formal, non-personal language presenting a picture of the neutral doctor and a patient with no voice.

Dialogue between patient and the physician occurs in only two cases (both from the Social Focus section) and another Social Focus case has at least two paragraphs of a patient 'talking' to the physician where the physician does not respond in dialogue, but through narration. All other cases describe the patient's and physician's thoughts through narration. This leads the physician to 'know' health details about the patient without being told by the patient directly through dialogue, possibly teaching students to make assumptions about patients without asking questions or putting pressure on them to know the answers on their own.

In the Cardiology cases, health practitioners are not described as having thoughts or personae. There is no text in any case reviewed in which practitioners are described to be thinking, having or expressing emotions, or questioning themselves regarding their interactions with patients or their decisions. In contrast, the Social Focus cases contain numerous examples of thoughts, feelings and emotions that begin to construct a persona for the health practitioner. For example, in one case the provider says to a patient, "sorry to have kept you waiting" and in another the provider says to a patient, "You seem sad." In a case concerning a patient who has a long wait ahead for surgery, the case narrator speaks directly to the reader (medical student) saying, "You feel sorry for Danny."

The place of emotion and concerns in clinical reasoning is made explicit in some of the Social Focus cases. For example, in one case the provider discusses the patient; saying, "Although I still had all her aches and pains to deal with, I was not worried about domestic violence". There is explicit attention here to the worry felt by the practitioner that may encourage them to continue to pursue something with a patient, in an attempt to resolve a perceived issue. In two other examples, the practitioner is described as acting on intuition or feeling, as feeling concern, and as worrying about the adequacy of care provided:

With these facts I felt I had a quick sketch of Mrs. Haddad, but no real understanding of her as a person or how her back pain related to her activities or stressors or her expectations of medical care. Her interaction with her husband seemed reasonable, and but I still felt that I was missing something of her history. (Social Focus II: Immigrant & Refugee Health)

After she left, I felt uneasy, wondering if I had missed something important because I wasn't comfortable asking sensitive questions with her husband serving as our interpreter. What if she was crying because her husband or someone else was abusing her and/or she was feeling suicidal? (Social Focus II: Immigrant & Refugee Health).

In both of these examples, the practitioner is conveyed as a feeling, caring, reasoning human being, in contrast to the Cardiology cases where the practitioner does not appear to think or feel, but is presented as knowing patient details. Again, there is a contradiction between the two types of cases regarding how to 'be' a doctor, but where there seems to be a priority given to Cardiology cases, being a neutral doctor may also take precedence. In the Cardiology cases analyzed, there is no discussion between the physician and patient, and no thoughts or feelings on the part of the physician are noted in any text in these cases. There is mechanical feel of the physician where symptoms are noted, diagnosis and treatment plan are given to the patient.

At the same time, the language used in the two types of cases differs markedly, constructing very different impressions of the health professional as objective, definitive, authoritative and competent, *versus* receptive, consultative, uncertain, and even tentative. Health professionals seem more confident through the language used in Cardiology cases, such as: "advises," "confirm(s)," "order(s)," "Your [doctor's] management plan," "prescribes," and "clinical assessment." Even the questions posed to students use language like, "How do you investigate this problem?"

In contrast, the Social Focus cases use language of approachability, concern and mutuality, such as: "you feel," "I think," "I need," "I recommend," "I'm concerned," "I'm wondering," "I'd like to understand," "it would help me to know" and "I felt uneasy, wondering if I had missed something." In one case the health practitioner reflects, "I gingerly moved toward questions about the source of her stress..." while in another the provider speaks directly to the patient, saying, "I think we can give you a lot of help here." Though definitely inviting patient trust, the provider still qualifies their authority saying "I think..."

There is a major overall effect regarding how patients are discussed by the narrator or physician in the case, either as people or as objects of study. Cardiology cases are more likely to discuss the patient as an object, a collection of body parts, or omit the patient completely from the conversation through language, such as: "There is no family history of cardiac disease;" "the precordial exam reveals no heaves or thrills;" "the second heart sound is physiologically split, the ECG demonstrates;" "Dr. Sharma reviews the history and available investigation results, and performs physical examination;" "the pulse is regular;" "the findings on physical examination are unchanged;" "how should Sarah be managed? What information in the history and physical exam in this case helps you in establishing the possible diagnosis?" By discussing the patient as an object removes their capacity to be a whole human being that is greater than a collection of parts.

Although there are a few personal details included in some Cardiology cases (5 patients have occupations and 2 play sports – hockey and soccer), it is not sufficient to present the patient as a person, due to the objectifying language and the amount of content

discussing body parts and symptoms, instead of a patient as a whole. This is what Foucault refers to as the “medical gaze,” where this language seems to attempt to stay objective, it hides the power relation that exists where the patient is incomplete and under that physician’s observation (Davenport, 2000).

In contrast, Social Focus cases include more personal details and a greater variety of details about the patient than the Cardiology cases. In addition to occupation and sports details, these cases also include details on family members and marital status, contributing to the patient as a person in the case and not just an object of study: four of 7 cases feature a marital spouse, and one case includes a fiancée. Family members, in addition to a spouse, are included as part of the discussion within the case, in six out of seven cases. Compared to Cardiology cases which mention a spouse for four patients and additional family members in two. With the addition of personal details about the patient, cases are teaching the students to consider patients as people, which may help them feel empathy for these patients.

Also, many patients in the Social Focus cases are shown to have feelings, either through direct statements or narration, which makes them seem more personal and relatable, for example: “she [patient’s wife] states that he has become anxious at his job; he says he is fine, just worried about his job and feeling like ‘nothing is fun anymore’;” “his fiancée, who knows that he [the patient, Jerry] had expressed interest in being an organ donor, feels that she cannot support ongoing aggressive treatment for Jerry;” “Mr. John is worried that his days at work might be ‘numbered;” “yeah, I guess I worry, but I don’t like to think about it [health] too much;” “my life is at stake here and I don’t want to sit around and wait to have this surgery;” “she seemed concerned;” “she breaks into tears when she sees her weight.” When patients express feelings in the cases, students may feel compassion for them and see them as real people and not just details in a case.

Only two Cardiology cases mention patients’ feelings. One states, “She is concerned as to the seriousness and long term outlook for her valve disease.” Another case reports, “Henry has been under a lot of stress. He hasn’t been doing well in school and has been drinking heavily to cope with hard times.” The rest of the cases portray emotionally-neutral patients.

The medical treatments that are discussed in these two types of cases differ, where all of the Social Focus cases recommended lifestyle changes, and the Cardiology cases have a mix of treatments: only two of the cases recommend lifestyle changes, three of the cases recommend surgery (which could have lifestyle change requirements), two cases prescribe medications (one is overlapped with medications and surgery), and in the final case there is no treatment recommended because the patient dies. The lifestyle of the patient is always discussed (usually as part of the reason for the medical condition), but might not be part of the treatment plan in the Cardiology cases.

Errors were found in the content, for example, where in one case a patient says: “I’m a black African Nova Scotian,” which is not a typical self-description someone would give. Members of this community, typically, would simply self-identify as African Nova Scotian or Black. Another case provides the description, “the patient was covered from “head-to-toe in a hijab”. In fact, for Muslim women who choose to wear the veil, hijab only covers one’s head and shoulders. Finally, the phrase “Aboriginal ‘groups’,” is used instead of Aboriginal ‘peoples’ or ‘nations,’ which suggests that these are merely interest groups, rather than sovereign nations. While such errors may appear minor, they seem to indicate a lack of expertise or awareness in the issues being presented in the Social Focus cases.

The point of view of most of these case studies (8 cases – four Social Focus and four are Cardiology) is through second-person perspective, with the narrator speaking to the reader (medical student), for example: “From your notes in his chart, you note that Marc believes he is healthy and he rarely sees his physician.” This style of writing gives these cases the effect of being instructions on how to “act” like a physician. Four of the remaining cases (3 Cardiology; 1 Social Focus) are narrated in the 3rd person, similar to a physician-written medical report, which would teach the students how to document like a physician. And the remaining case (Social Focus: Cultural Competency II – Immigrant & Refugee Health) is presented in the first person by the family physician included in the case and begins with, “The first time I met Mrs. Haddad, I was running late.” This perspective would give the student examples on how to think, feel, and communicate like a physician. Using these diverse points of view may be helpful in teaching students a well-rounded view on how to be a physician, but depending on how each style is used with content affects how patients may be viewed by the students. For example, if the third person narration is only providing symptoms and information, describing patients as objects, student may adopt this way of thinking. This will be discussed further below.

Finally, in some of the Social Focus cases, the discussion questions included invite students to engage in critical self-reflection concerning how the interaction with a patient unfolded: “Could the lack of follow-up have been prevented? Could Dr. Jim have done a better job of understanding Mr. John’s situation? Could he have developed a better relationship with Mr. John so that Mr. John would have understood the importance of taking his meds and would have felt at ease returning to ask for another copy of the requisition?” (Social Focus: Cultural Competency Week 1); “Reflect on stereotypes and attitudes you have seen expressed toward Aboriginal people in Canada and your own personal relationship to these communities” and “...you heard reference to a ‘treaty person.’ What does this mean? Discuss your own perceptions and reactions to this idea” (Social Focus: Noah Denney – An Aboriginal Health Case); “What if instead of thinking about advocating for Danny, you were faced with a close personal friend asking for your help to advance their surgery date? A spouse? A fellow physician? (Queuing

with Danny – Waitlist Management); “How are you managing your sleep needs? Do you have to use caffeine in an attempt to compensate for insufficient sleep at night? Are you able to make time to get enough sleep, eat well, and exercise?” (Effects of Sleep on Health, Safety and Society).

Among the Cardiology cases, critical self-reflection is not invited through discussion questions where concerns outlined in these questions are for the purpose of patient diagnosis, pathology, tests, assessments, causes of medical condition, treatment plans, and complications or risk of developing further medical conditions: “Based on your clinical assessment, what do you think is the underlying diagnosis?” “What are the possible causes of this valvular abnormality?” “What is the pathology of mitral stenosis?” “What diagnostic tests should be run?” “What findings do you expect on the physical exam?”

The above analysis describes how two types of cases that are used for the formal medical curriculum, differ in terms of format, content and language, for the purpose of discussing whether these differences affect how the students experience the formal curriculum. Next, these case studies will be analyzed for their social class content.

Descriptive Analysis of Social Class in Cases

This analysis will give an overall picture of how social class details are included in the cases in terms of how the practitioners and patients are described. This content and the language used provide knowledge on social class for the students. The amount and type of detail provided vary widely, providing more or less information about the patient and provider as people, in terms of their family situations, jobs, hobbies, financial situations, living situations, race and ethnicity, and so on.

Who are the Practitioners and Patients?

Half of all cases (7) feature a family physician as the primary healthcare practitioner in the case, with Emergency Department physicians (neurologists, radiologists, cardiologists) as the second most common type of practitioner (4 cases). No personal details are given for any health practitioners, except in one Social Focus case where the family physician is noted to have children, “His children used to hang out with yours...,” and participate in sailing: “...a cardiologist whom you sail with in the summer.” Also, no hierarchy among specialties of physicians is noted. The absence of any details about social, cultural or economic circumstances renders the practitioner ‘neutral’ in sociocultural terms. In other words, the practitioner as person, as social being and community member, is rendered invisible or irrelevant. Practitioners are constructed as interchangeable. Who the practitioner is, in social terms, is conveyed as not mattering to the patient encounter. This lack of details also allows for assumptions to be made about the practitioners, for example that they are white and male.

Though practitioners may come from a range of sociocultural backgrounds, once they are practicing in health care they are likely to enjoy relatively high income, which brings with it certain protective factors regarding health outcomes. In contrast, among patients there is a potential array of social class backgrounds. As made explicit by the World Health Organization, the Social Determinants' of Health are "the conditions in which people are born, grow, live, work and age," which need to be considered in effective health care work (retrieved from: WHO website - http://www.who.int/social_determinants/en/)

Occupation is one component of social class and Socio-Economic Status, and is included as a Social Determinant of Health. Some of the occupations assigned to patients in the cases analyzed would be considered working-class, such as Journalist, Paralegal, Labourer, Farmer, Fisherman, "summer job installing siding for a construction company." A few others could be considered middle class: Engineer ("responsible for projects throughout New Brunswick and also frequently attends meetings in Nova Scotia as the NB representative"), "was a successful businesswoman," and "she worked as a Lab Technician in China, but has yet to find employment in Canada." Three of the remaining patients are students, where one is stated to be a university student, and the final two cases make no reference to the patient's occupation. Other than possibly the Engineer and the patient who was a successful businesswoman in her home country, none of the occupations would come close in income and/or professional status to the physician, which could create a power differential between the physician and patient.

The educational background of three patients were: two are university students and one is a generic student ("moved to the city to study"). This could indicate middle class status, though as students they would still be considered to hold less status than the physicians. None of the patients are stated to be "university-educated" where a university education has been completed, however, the patients with middle class occupations (engineer, business) would likely have university educations.

Where a person lives is used to indicate social class and in these cases the housing situation of four patients is discussed. For example, one patient is said to live in the same community as the doctor, an adult Aboriginal man and his family live with his parents in a Mi'kmaq community on Band property, a Muslim woman "lives in a house with 14 people," an Acadian woman lives "...in the small town where she grew up."

Only cases that concern lower income patients explicitly discuss patient income, and this discussion is directly related to the cost of medication. For example, in one case a patient inquires about insurance coverage for a prescription: "Those pills you're talking about – are they covered for me?" In another case, a patient's financial concerns are raised regarding medication costs and lifestyle changes: "Mr. John tells you that he is worried that he cannot afford to be a diabetic. The medication he was given is expensive and changes to his diet are even more expensive and overwhelming." In the

same case, the narrator says of the patient, “he simply cannot afford to stop working.” It is noteworthy that in both cases where patient income is explicitly raised as a concern, the patient is also a member of a visible minority group, which can lead to reaffirmation of harmful stereotypes.

The way that a person cares to, or is able to, spend his or her free time in sports, also signifies or symbolizes membership in a particular social class bracket. Bourdieu (1978) discusses the distribution of sports across social classes where the type of sport one undertakes is related to the social “profit” one expects to gain from it by being associated to a particular group (p. 835). He continues to discuss how sports such as golf and equestrian, which are somewhat reserved for the upper classes not only due to cost, but also through memberships, “family tradition” and “early training” (p. 838) and that effort is made to keep these sports closed to lower classes. The popular vulgar or violent sports, such as wrestling or boxing, which are played to become strong and muscular, would repel those from the upper class and are played to varying degrees by the middle and working classes, as their free time and economic resources allow (Bourdieu, 1978). Wilson (2002) discusses “prole” (short for proletariat or working class) sports (p.5), which are avoided by the upper classes, for example boxing, rugby and football.

Only two types of hobbies were referenced in the cases analyzed, where one adult patient is said to referee hockey and another, who is a high school student, plays soccer. Due to the expense of playing hockey, this patient could be working or middle class, but this type of activity may not be popular with someone from the upper classes, according to the above assumptions. The high school student could be from a working class or middle class background. Soccer is not necessarily an expensive sport, but the student would need to be driven to games and practices, and possibly tournaments away. Soccer would not, in general, be considered a hobby of the upper classes. So both of these cases indirectly give impressions about the social class status of the patients.

The social determinants of health are normally not included in any discussion of a patient’s treatment, with the exception of two where the patients are deemed to have low income and possible difficulty affording medication. However, some of the cases offer students readings and information on this topic, such as in “Noah Denney: An Aboriginal Health Case” three background readings were included on the social determinants. But, in the case discussion of treatment for this patient, there is no attempt to integrate considerations of social determinants of health into practical application, other than to discuss the patient's low income and inability to afford the prescribed medication, which only acknowledges the issue and doesn’t suggest any solutions. Most of the treatment prescribed for this patient requires him to make drastic changes to his lifestyle, with little to no guidance on how to do so, even in the face of extreme social determinants affecting the patient's health.

The tutor guides for two cases include mention of concepts related to the social determinants of health: “Immigrants may have experienced diet, lifestyle, and community ties from the country of origin that may be healthier than North American norms” (Social Focus: Cultural Competence II – Immigrant and Refugee Health); “Another contributing factor could be the proximal and distal determinants of health associated with being a member of a marginalized racial minority; in particular, the high level of stress caused by economic hardship, and the stigma of being ‘racialized’ by his boss” (Social Focus: Cultural Competency – Week 1: Mr. John and Ms. Claire). Again, although it is important to acknowledge this social determinant of health, there is no practical application suggested regarding how to use this knowledge in the care and treatment of the patient, which may prevent generic treatment plans that do not consider a patient’s ability to fulfill them.

One case includes these social factors in the preamble to the patient case: “Minority Groups that are already disadvantaged by (say) a lower SES are further disadvantaged by racial stereotyping and by communication difficulties, which can result in reduced access to care, inferior quality of care and inferior health outcomes: This session will focus on a key social determinant of health: ‘racialization’” (Cultural Competency, week 1: Mr. John and Ms. Claire). Application of the social determinants of health framework in this case is through the discussion of the patient having a low income and not able to afford the medications that are prescribed to him. However, in contradiction of the social determinants of health, the patient is asked by his physician to make major changes to his lifestyle, without any resources or guidance on how to make these changes, and without consideration of his social determinants.

In summary, although a small number of cases make an attempt to educate about the social determinants of health, this information seems to be only theoretical. There is no connection made to practical application of this information when discussing and treating the patient. Without being able to apply content, students may dismiss this information altogether as not useful.

Discourse Analysis of Cases

In addition to performing a descriptive analysis of the cases, I analyzed these cases for discursive elements that occur through the content and language that are included, as well as identifying power outcomes, through a Foucauldian-inspired framework, as described in the previous chapter, to show how a medical school constitutes social class through a sample of its formal curriculum. Concepts and language present in these medical curriculum cases are understood to be articulated to broader societal systems through the concept of governmentality.

Governmentality

As mentioned in the previous chapter, governmentality is described by Michel Foucault as the way individuals act out or normalize certain societal norms and expectations as proscribed, and prescribed, by governing forces, which are able to govern at a distance. Individuals behave in expected ways due to unseen pressures that continue to guide them as objects in fulfilling the wishes of society (Ettlinger, 2011). Medical curriculum reveals how neo-liberal governing forces, in this instance operating through the medical school and possibly the medical establishment at large, construct social class, both through how it is discussed or and how it is not discussed. This constructed knowledge is reproduced through the formal curriculum, through lectures, by faculty tutors, and by students, as the objects through which the governing forces act.

Governmentality guides institutional processes such as a medical school curriculum through mechanisms that are subconsciously “enacted” through the “subjects,” such as school directors, curriculum planners, case writers, and medical students, to help promote the ideologies of larger governing bodies (e.g., neoliberalism) (Stickney, 2011). The ways in which governance acts through the curriculum will be discussed using three concepts, or mechanisms. ‘Individualizing the social through health,’ involves the patient being constructed as largely responsible for maintaining or obtaining “good” health through practice of a “healthy” lifestyle. The mechanism at work through the curriculum draws on and recirculates broader social discourses wherein good health and healthy lifestyle have been normalized in society (e.g., the ParticipACTION exercise campaign and the Canada’s Food Guide suggestions for healthy eating) which tell good Canadian, good and moral citizens, how to fulfil; their responsibilities for self-care on behalf of the neo-liberal state. The concepts good health and healthy lifestyle may be based on middle or upper class lifestyles, with their inherent resources and values. ‘Subjectivity’ is a second mechanism whereby the subjects or individuals have internalized the governing forces through either self-governance or the construction of particular discursively-available identities, characterizing them as either good or bad. A third mechanism, ‘agency,’ shows how the subjects involved (case study patients and physicians) either reinforce or resist the social class discourses encoded in the curriculum through their designated ability to do so.

Individualizing the Social through Health

According to Rudman and colleagues (2013) “individualizing the social” is a process of neoliberal governance through which matters that are social and political are discursively rendered individuals (p.302). Broad social conditions, such as rising unemployment, and escalating rates of chronic conditions, are cast as individual failings or the result of poor choices. In terms of health, this means that individuals are expected to take responsibility for their own health, either by maintaining or achieving “good health” and all individuals are seen as having the same ability to make these “good health” choices regardless of social class circumstances.

If health is an individual responsibility, when one's health is not good, as deemed by a medical professional, it is up to the individual to make themselves better, mainly as prescribed through a change in lifestyle (e.g., exercising regularly, following the Canada's Food Guide, and getting regular health check-ups): "In managing chronic disease, success depends greatly on the knowledge, determination, and skills of the patient. The role of the physician is to support this process." "The time is right to tackle some of the lifestyle issues that place him at risk of CVD." "smoking, lack of exercise and maybe the foods you are eating are all contributing to your high risk." "He (internist) recommended a program of moderate exercise and some dietary changes to help reduce Danny's risk." "You arrange to see Marc again in 2 weeks to recheck his blood pressure and to assess what changes he is making to his lifestyle and activities." "His referral to a cardiac rehabilitation program will ensure that he is offered individualized advice about diet, weight control, and exercise. Exercise prescription typically requires consideration of age, pre-infarction level of activity and detailed knowledge of his cardiac status." "Students should be encouraged to read about the benefits of dietary modification following myocardial infarction, in particular the evidence for a diet low in saturated fat, high in polyunsaturated fat, high in fruit and vegetables and possibly incorporating fatty fish/omega-3 polyunsaturated fatty acids." Comments such as these, embedded in the cases, convey and reinforce the notion that health and ill-health are individual responsibilities.

However, the ability of the individual to make themselves better through lifestyle changes is not discussed in terms of social class or any other possibly limiting factor, even when the patient tries to draw attention to social class related factors that may limit their ability to manage their own health. For example, one case states:

A focus on more immediate concerns (e.g., employment and income) may impede his [patient's] sense of control over his health. A sense of hopelessness and lack of control deriving from the historical experiences and social conditions in his family and community may also affect his ability (and his family's ability) to manage and address chronic disease prevention and management.

Some individuals may have to decide between their health and their employment, as shown in two examples where patients experience low income and job insecurity: "I've got to get this taken care of 'cause I've got to get back on the boat," And, "It's not just a job. I still feel from day to day that it could be taken away from us again. I can't take it for granted. I have to be out there." In another case, income and employment demands are presented as interfering with ability to adhere to optimal treatment.

He (patient) tells you that he cannot afford that many pills at a time. Mr. John is worried that his days at work 'might be numbered' and wants to have a little money set aside should he lose his job. In fact, he had been unable to make it to the clinic lately because of his boss, and when he needed his prescriptions he had been going to the walk-in clinic next to work during lunch hour.

Income is certainly a social determinant of health as deemed by the World Health Organization, and although it is acknowledged in both these cases where these patients cannot afford their prescribed medications, consideration for neither their low income nor job insecurity is integrated into their treatment plans.

In another case where the patient must possibly choose between his health and his job, a patient is given a long list of lifestyle changes that he should accomplish:

You review aspects of sleep hygiene and talk to Marc about shutting down the computer at 11 PM and going to bed before midnight, increasing his physical activity, improving his diet, and decreasing his weight. You advise Marc that you are particularly concerned about his 'near-miss' accidents and that in some jurisdictions it is mandatory for physicians to report sleepy drivers to the Motor Vehicle Board

The power of authority is barely veiled here where the physician has the power to affect this patient's ability to work, if he does not adhere to the lifestyle changes that are prescribed. Clearly the consequences of not self-resolving one's health problems through adherence to this list of lifestyle changes could impact patient employment, as evident as the case continues:

You tell Marc that until his sleep issues are resolved he is not to be on the road for more than an hour at a time after 3 PM; if he is more than an hour away from home at the end of the workday, he is to stay overnight. You secure his agreement to this arrangement and make careful notes recording your discussion. You arrange to see Marc again in 2 weeks to recheck his blood pressure and to assess what changes he is making to his lifestyle and activities. In the interim you refer him to a sleep testing facility.

As these lifestyle demands may infringe on this patient's ability to do his job, a dilemma of choice may occur where the patient feels he needs to choose his job or his health. If he chooses his job and his health is negatively impacted as a result, it is his own fault.

Further instances of when lifestyle changes are expected occur when patients are in need of transplants, where a patient could lose their priority for an organ if they do not follow healthy lifestyle practices before transplantation. This may be to "prove" that they will take care of the new organ or "resource allocation" as the transplantation of organs is described. In the tutor guide for the topic of transplantation, students are asked, "Should social factors (such as alcohol use and social support) be part of this assessment, both in terms of being on the waitlist and in terms of who should receive the liver?" A suggested response is, "It is clear that the MOTP (Multi-Organ Transplant Program) does not exclude persons with alcohol issues, but that it does demand abstinence while on the waitlist. This is framed as not doing any additional damage to their current liver and overall health, but also may factor into the success of a liver transplant." This request for abstinence from alcohol may be a significant lifestyle change for someone and could impact whether a transplant goes forward. An inability to

change one's lifestyle in terms of alcohol consumption, could impact whether they are allowed to receive a new organ and could have a life or death result.

A similar dilemma to the above exists in waiting for surgery where a patient is also responsible for obtaining or maintaining good health. In a discussion question on the topic of designing a wait list the following "questions to consider" when designing a waitlist for patients were included in the student and tutor version of this case: "A minimum, criteria-based threshold for level of impact on activities of daily living should be set. Once this is met, it should be first-come, first-served." "Priority should be based on capacity to benefit as defined by expected effect on patients' ability to work and function in daily activities." "Priority should be given to patients who don't currently smoke as smoking has strong and negative effects on outcomes." "Criteria should be set to maximize the number of quality-adjusted life-years gained." These criteria can be directly related to lifestyle where a patient, who may already be ill awaiting surgery, may possibly have to adjust their lifestyle in order to be considered for surgery. Again, there is no discussion of possible social barriers to attaining these requirements to be on the waitlist.

Good health has been normalized in our society through middle and upper class values and resources (e.g., join a gym/exercise regularly, buy fresh produce), but obtaining or maintaining this same definition of good health is held as the responsibility of all individuals, regardless of social class, and could set up people to fail who have significant social class barriers, such as income, neighbourhood, employment insecurity, and differing value systems. When individuals 'fail' in terms of their health, it is deemed as being their fault alone and these messages are reinforced through some of the medical curriculum, as they are seen in larger neoliberal governing forces, such as medical institutions, governments and society.

Subjectivity

In the above section it was shown that the cases in this sample of a medical curriculum suggest individuals are responsible for attaining or maintaining their health. This section will discuss how the categories 'good' and 'bad' are used for individuals according to how they are caring for their health, which may extend to their moral valuation as people as a whole. Through discourses on good and bad lifestyles or health behaviours in the curriculum, we see how patient or physician subjectivities are expressed, themselves, as inherently good or bad. Social class circumstances are not overtly discussed when 'subjecting' one as either good or bad, however societal stereotypes would lead one to connect certain lifestyles and health with certain social classes. Also, individuals with social class barriers may be more likely to be constituted as bad patients with bad health due to limited resources (income, support), neighbourhoods, and employment insecurity.

Although most discussion in the cases involves good and bad patients, there is one case that discusses how to be a good doctor through lifestyle behaviour: "It is expected that the discussion will help students to gain an awareness of their own sleep needs and the consequences to themselves and their patients when these needs are not met." It is hoped that students will "appreciate their personal responsibility to obtain adequate sleep and rest." The demands of their job could affect their abilities to obtain adequate sleep and rest and they may have a dilemma in choosing between the two. But, other than this observation, the health or health demands of physicians and other medical professionals, including students, are not discussed, possibly suggesting that their health is naturally good or that their lifestyles and subsequent health are of no concern to this piece of medical curriculum.

However, there are many examples of how one can constitute oneself as a 'good patient.' The good patient is concerned about his or her health and takes steps to maintain or improve health. All of the cases mention patient lifestyle in relation to the health issue concerned, sometimes as a cause of ill-health. Out of the 14 cases, three patients are deemed to have healthy lifestyles where no changes to behaviour are prescribed by the physician because they are already 'good patients' looking out for their own health: "...he had always been an extremely active individual;" "She does not drink alcohol, smoke, or partake in any recreational drugs. She drinks one cup of coffee per day" and, "The goal with Mrs. Haddad is to maintain her good health..." Two cases mention that a patient had made improvements to his or her health, without physician intervention: "Danny quit smoking several years ago..." and again, "He stopped smoking about 10 years ago."

Another subject position available in the texts for the construction of 'good patients' is the patient who 'follows doctor's orders.' This compliance with expert advice is ostensibly rewarded with improved health. In one case the patient "comes back a couple weeks later, saying that his back pain was improved by the ibuprofen and by his modified duties." Another case notes that that patient took numerous measures to improve his health:

Mr. John returns the following week. He tells you that he has given up drinking and eating salt. He has also cut down on his smoking. He has been taking his new medication and checking his blood sugar. He cannot afford to buy a monitor, but his uncle has loaned him one. He tells you that he is really motivated to 'get better,' because he knows what it means to have diabetes and he really does not want it.

In a third case, a patient is described as directly following medical advice: "Marc reports that he is now going to bed at 11:00pm and falling asleep within half an hour or so."

The moral worth of the good citizen who complies with self-governance, regulating his or her own health through taking individual responsibility, as promoted through society's governmentality, is made particularly apparent in a case about organ transplant where a

'good' patient is rewarded with a, potentially life-saving, organ. As noted above, in order to receive a liver transplant, a patient is required to comply with prescribed healthy lifestyle behaviours, so as to deserve a new organ. The patient is described as "compliant with medical treatments and visits. Abstinent from alcohol past 12 months and has passed 2 random alcohol tests." Similar descriptions are offered about other 'good patients.'

Again, in discussing this case on organ transplant, social class issues are made explicit where one discussion prompt in the tutor guide says to, "ask students to consider the consequences of always giving priority to those who will benefit in most quality life-years saved – would that lead to treating the healthiest, and abandoning the less healthy? In socio-economic terms, what will that mean?" When there are healthy lifestyle requirements placed on whether a person receives a transplant the system may, as the tutor guide subsequently states, "systematically deny those who are already disadvantaged by poverty or by worse health states..." Those who experience poverty or worse health may often be one and the same. Discussion questions about how to consider social factors when prioritizing transplant recipients are "deliberately left open to help stimulate discussion." However, the relevant reading added to this question is the Multi-Organ Transplant Program of Atlantic Canada (MOTP) Liver Transplantation Consent Form, which does require healthy lifestyle, including dental health, which would only be available to certain members of society. This document and its lifestyle requirements may influence the discussion towards favouring patients who meet these requirements. In other words, if students are being encouraged to openly debate the role of social factors, yet are provided an authoritative document that states current medical practice is to require abstinences from alcohol and other healthy lifestyle measures, it is likely those items will influence their concepts of "good patient."

When a patient does not take responsibility for their health or does not follow doctor's orders, they are constituted as a 'bad patient.' A bad patient is one who engages in 'unhealthy' lifestyle behaviours or who is in poor health due to such behaviours. These unhealthy behaviours are deemed to be choices, as these patients are individually responsible to regulate their actions. A key instance when a person may be deemed a bad patient, appears to be when they don't see their family doctor regularly. One case states: "Paper file lists a visit 7 years ago for a laceration, which required sutures" and continues "...he has not been to the clinic for just over a year." In another case, "Marc believes he is healthy and he rarely sees his physician." Another patient does not follow-up with his physician, "He was asked to return in about 2 weeks but seems to have forgotten to do so," while another "rarely sees his family physician." So-called 'bad patients' may have valid reasons for not taking care of their health, possibly due to social class barriers, but this is not discussed – implying that an individual may also be responsible for overcoming social class barriers, in addition to improving their own health.

Another factor that may constitute people as ‘bad patients’ is a lack of motivation to see the doctor. Two cases specified that a patient’s wife insisted on the appointment: “After the second episode, his wife insisted on this appointment” and, “He said that he wouldn’t ordinarily bother you but that his wife demanded that he make his appointment” (Effects of Sleep on Health). In a third case a patient has to be reminded of risk factors by his wife and persuaded to go to hospital: “He reluctantly agrees and drives himself to hospital after breakfast” (Jack Macdonald: A Case Of Acute Coronary Syndrome). Again, there may be many reasons why a person is not motivated to see their family physician regularly, but the case does not make any overt prompts for discussion of this, leaving an assumption that the patient is solely to blame for their behaviour.

Our society governs what is characterized as healthy lifestyle behaviours, such as abstaining from smoking, eating healthily, exercising regularly and getting enough rest; these behaviours are reflected in the analyzed piece of medical curriculum. Taking part in unhealthy lifestyle behaviours would be considered bad, as several descriptions of patient behaviour depict: “He is a smoker.” “...drinks one beer a night and ‘a few more’ on the weekend.” “...has been drinking heavily...” “...eating more than usual.” “He eats healthy food at home, but whatever he can grab when on the road. He has gained weight steadily throughout his 30s (approximately 5 lbs/year)” “He drinks copious amounts of coffee, approximately 8 cups/day, especially in the morning.” “She is not exercising regularly.” “He used to enjoy hockey in the winter and baseball in the summer but has found that over the past few years, with his work schedule and 2 young children, it is not possible to belong to a team. He joined a gym last year but rarely goes.” “Closer questioning reveals that Marc has always been a ‘night owl’.” In detailing risk factors students need to watch for, the cases also constitute the patient responsible for their own ill-health, the “bad patient.”

Somewhat ironically, there is also a limit for healthy behaviour, and in the case of exercise, too much could also present medical issues: “A family history reveals that Sarah’s cousin died while swimming at age 15.” “Symptomatic patients should not participate in competitive sports.” “He has found himself more short of breath and having less energy with significant activities, such as when he referees fast-paced hockey games or shovels snow.” “The fainting spells happen usually when I’m exercising or exerting myself...” The apparently narrow window of ‘good’ actions to govern one’s own health constitutes the physician as the authoritative expert; patients are fully responsible for health and health-promoting behaviours, but are expert in knowing what those behaviours should be.

In discussions of overweight or obese patients, weight has also been normalized where the parameters of acceptable body weight are relatively narrow and are a clear marker of ‘good’ or ‘bad’ patient. Cases describe patients as, “She tells you she is healthy, but that she has always struggled a little with her weight,” and, “Physical examination is normal other than moderate abdominal obesity.” Students learn to use the Body Mass

Index (BMI) to categorize people as normal weight, overweight or obese. This index does not take into consideration bone structure or muscle mass leaving some athletes categorized as overweight using this scale. Yet using the index objectifies the classification of people into weight (and moral) categories: "...giving her a BMI of 28.7 (overweight)"; "Students should calculate Marc's BMI (weight/height²) and note that he is obese (BMI \geq 30)...You tell Marc that you are concerned with his present physical condition including his weight." Classifying people as overweight or obese is simultaneously a classification of their success in self-governance as a good patient and moral citizen, ensuring their own good health, since body weight is discursively linked to health and ill-health.

It is also implied in this sample of the medical curriculum that people (good patients, good citizens) should want to be healthy and when given knowledge or instructions by a physician, should use this information to go get healthy. Thus noncompliance with medical advice clearly constitutes someone as a bad patient: "Mr. John had discontinued the antihypertensive meds. He had lost the requisition for blood work and had not come to get another copy." In another case, a physician asks a patient to modify his work duties to give his back a rest, and the patient is unprepared to commit to this. In one case a patient admitted to actions that would constitute him as non-compliant: "admits he didn't take the week off, but went back to the boat as scheduled... He didn't take the ibuprofen either..." And lastly, one patient in a case constitutes himself as bad patient by missing an appointment: "He misses his scheduled follow-up appointment to see you."

These examples of 'bad patients' are depicted as suffering consequences through medical conditions that could have been prevented, if they had taken responsibility for their health through a healthy lifestyle. The notion that if we are unhealthy, it is our own fault for not taking care of ourselves is the current neoliberal view that is prolific through governing forces, including some of the medical curriculum. Governing forces dictate that we are supposed to be motivated to care for our health and when we don't and our health fails it is our fault.

In the previous two sections, I have demonstrated that the medical curriculum I analyzed implies that it is an individual's responsibility to be healthy through good lifestyle behaviours. To 'choose' not to do so constitutes the person as a 'bad patient.' The next section discusses physicians' and patients' power to act in their lives, which may have an impact on their ability to take responsibility for their health and be 'good'.

Agency

Agency is described by Michel Foucault as governance over self and having the power to act. In the medical cases analyzed for this research project, subjects (health practitioners or patients) are shown to either reproduce or resist the normalizing social class depictions in the healthcare environment (Stickney, 2011). In the previous two sections, I described how patients are responsible for obtaining or maintaining a

proscribed level of good health, regardless of background, and are also constructed as good or bad based on their lifestyle behaviours, which may be a result of their abilities or power to act, or perceived power to act. This section will discuss the individual's ability to act, or their agency, in situations that might affect how they are constituted as patients, taking responsibility for their health.

Physicians are normally seen to have the most power to act in the medical encounter, as depicted in the cases, with patients shown to have diminished power to act, though they carry tremendous responsibility for their own health. The assigning of agency in the written cases starts from the very language used, which tends to assign the 'main character' role in the case to practitioners. They are the agents in the scenarios, the actors, while patients are typically the objects, those acted-upon. Cases are narrated from the perspective of the physician who also directs the flow of communication with the patient and is shown to establish control of the communication immediately when there is interaction mentioned in the case. In the cases examined, physicians introduce themselves, ask patients about their symptoms, examine patients, take detailed histories, and inform family members about health issues as appropriate. In contrast, patients and family members appear to be relatively passive objects, sometimes seeking permission from physicians: "Marc is now sitting in your waiting room. As you call him in, his wife asks if she can join him." With the physician setting the stage for being in control of the interaction, as the cases establish the physician as agent, actor, and the patient as recipient of expert attention.

As some patients may already be feeling intimidated by physicians, if these people are not involved in their everyday social environment, so another layer of power and hierarchy may leave them feeling even further removed. It is ironic that the patient has so much responsibility over their health, yet is constituted as having so little power to act in the medical encounter. This inherent hierarchy and power of the practitioner may teach the medical students that this is the expected way to behave and may lead to perceptions of power to act for both physicians and patients, once outside the medical encounter. For patients feeling they have no agency within the medical encounter, they may expect that the physician will help them get better and not that the responsibility to improve health will reside largely with them.

In some cases, the patient actually speaks first, but they must first "present" themselves to the physician, in other words they need to be acknowledged by the physician before they can speak and this strategy gives the physician power and agency without needing to speak first. Patients are depicted in the cases as "presenting" to their physician with symptom, reporting or complaining of symptoms, and "telling" physicians about their health or illnesses.

When patients are given a voice or agency in the cases, they are often shown as not quite understanding why they need to set different priorities in terms of their health,

which would also interfere with their ability to take responsibility for their health. Even when patients are given dialogue or voice, the exchange is controlled by the physician and the content of the patient's speech is seeking help, information, and guidance from the physician. Also, they may be shown as unable to understand the 'right' priorities for maintaining or improving their health. Two examples are from cases in which the patients have been described as having low income: "What do you want me to do?" and, "I don't know what to do" In another case, patient passivity is attributed to geographic location: "You've noticed that patients in this community aren't as assertive as patients you were accustomed to dealing with in the city." And in yet another case, the patient seems to enact agency, refusing to take medication, yet is shown to be in error: "They prescribed me some pills for the pain. It hurt, but I wouldn't take them 'cause I didn't want to get hooked.'... You (physician) explain that the ibuprofen isn't going to expose him to any danger of addiction." These particular examples involve very simplistic health information, reinforcing the low income equals low health education stereotype, to the point of making these patients seem very uneducated and dependent on the doctor. These dynamics listed above delineate a huge gap in the intellectual capacities and capabilities of these physicians and patients, which would not be accurate across all encounters.

The discrepancy in the cases between physicians and patients regarding agency is compounded by an implicit or explicit differential in social class status. Sometimes when a patient speaks, slang is used. This may be an implicit depiction of social class or education level and where the physicians in cases never use slang, this difference elevates the physician in the encounter, creating a power differential. In one case a patient says of avoiding pain medication, "I don't want to get hooked." In another case a doctor paraphrases a patient as saying "His stress has been 'through the roof,' while in another case parents describe their son as having "always been a fighter." In all cases, the physician only uses proper English, which may add to the perception of superiority of physician social class.

One case, in which patient and physician seem to share a class status, reads very differently from the others. In the description of the patient, he "lives in the physician's neighbourhood and attends similar social functions." The patient is also assigned an unusual degree of agency in the encounter: "Danny comes into your office, shakes your hand and greets you, 'Hi Don!'" This patient speaks more than all but one patient, in the cases analyzed – 14 sentences of dialogue. The content is mainly concerned with the patient's health issues and wait times and dialogue is directed by the patient. In addition, this is the only case of a patient offering a diagnosis himself: "'Do you think I have angina?' You (physician) suspect that he might be right." This patient's enactment of agency continues as he suggests that he could go elsewhere and pay for required surgery.

As depicted through these cases, most patients are granted little agency in the text, little power to act and govern self, both through their perceptions and their realities. They

rarely have a voice in the cases through dialogue while the physician normally just 'knows' the patient's details. When the patient's voice is silent, it is only the physicians' interpretations that matter, even though these may be partial. Although there is an attempt to show social contexts of patient's lives, when people have lower incomes, these individuals are shown to not properly take care of themselves, either through avoidance or lack of knowledge or education, which is not an empowering depiction+ of these individuals.

Possibly one of the most significant ways of diminishing the agency of the patient is through de-personalizing language, where the patient is discussed as an object more than a person. Most commonly, the patient is not referred to at all, rather they are discussed as symptoms, findings, or a set of test results. For example: "A full trauma workup as done which showed no injuries except for a skull fracture." "There was traumatic subarachnoid hemorrhage seen with evidence of diffuse axonal injury." "On examination, there is equal bilateral reaction of his pupils with a minimal gag reflex but there is no other response to stimulation." "The Electronic Medical Record (EMR) lists "back pain" as the reason for today's visit." "The precordial exam reveals..." "What does the ECG show and what is your working diagnosis?"

The patient, then is reduced to a 'history' as stated in the case: "There is no past history of any illness or surgery" and in the discussion questions: "How does *the history* help in Sarah's (patient) case?" "What features of *the history* are most important?" "What features of the history might help in determining the cause?" In turn the patient and their condition becomes something for the physician (the agent) to "manage:" "What is your immediate approach to management in the Emergency Department?" "What is your [doctor's] management plan?" "What is the appropriate management?" When the patient is an object or reduced to a "history," their agency is compromised.

Even when explicit attention is given to patients being real people, with complex lives that need to be fully taken into account, the language of the cases often renders them objects to be managed rather than agents. For example, the discussion questions for one case ask, "What are some of the *patient barriers* that physicians must face in supporting quality care?" and "What else must be done to help prevent and *manage* substance abuse and addiction in Aboriginal communities?" (emphasis added).

An individual's agency or power to act in the medical encounter could be indicative of their perceived or actual power to act outside of the medical encounter when they are expected to take responsibility for their health, possibly with a list of changes to make in their lifestyle behaviours.

Summary of Case Study Analysis

From the above descriptive and discourses analyses, I observed that both structures and language have an influence on how social class is included in the curriculum. The

formatting structure of the cases that contain mainly social information on patients is less consistent, seeming less professional, in addition to having authors not necessarily experts on the case topic. With little social class detail in the Cardiology cases, this structure assists to separate biomedical information from social information into segregated issues. The structure of the incidences of social class further lessens the impact of this topic on the curriculum where social class is almost only described for the patient, as if this is something only patients have and not health professionals. Also, by focusing mainly on occupation and income as indicators of social class, one may be quick to categorize a patient into a social class group. When content on the Social Determinants of Health is introduced in the analyzed cases it is in theory only and not taught in a way that is applicable in the patient encounter. This lack of applicability may make this content unusable by students in a highly-practical field.

In terms of the discourse analysis of the textual content of the cases, a few main themes were identified with reference to how social class is discussed. First, using Foucault's concept of *Governmentality*, it is seen how descriptions of social class reflect the greater neo-liberal society that we live in as income and occupation are the main focuses in discussing social class. This societal structure also focuses on an individualistic way of being and the second theme of *Individualizing the Social in Health* shows how the individual is mainly responsible for obtaining and maintaining good health according to general mainstream societal definitions. Through *Subjectivity* it is seen how patients are categorized as either "good" or "bad" according to how well they follow doctor's orders and a theme of *Agency* helps illustrate where a patient has the power to act in obtaining or maintaining their health. A patient who is described as "bad" and shown to have little agency over their personal health, possibly due to negative social determinants of health, is still described as being responsible for obtaining good health. This situation exists in the real world and reiterated through this formal curriculum, instead of providing solutions to help these individuals through health care providers.

In the next chapter I examine the experienced curriculum, analyzing interviews with students to explore how they *experienced* social class content through their formal curriculum to see whether they will reiterate the themes discussed above or if they will resist some of the power discourses that oppress individuals from certain described social class groups.

Chapter Five: Data Analysis – Student Interviews

The following is an analysis of “experienced” curriculum as reported by medical students on the formal medical curriculum, to complement the previous analysis on the “delivered” curriculum as described through case studies from the formal curriculum (Prideaux, 2003, p.268). This chapter will describe how these six students experienced social class content from their formal curriculum, including the case studies described in the previous chapter.

Descriptive analysis of interviews

As mentioned in the methods chapter, I interviewed 6 medical students who had just finished their second year of medical school, which means that they had completed the majority of the classroom study requirement of their programs. These students would have used the same case studies in their programs as were analyzed in the previous chapter. However, regardless of what is intended or delivered by the curriculum through reading, interpreting and discussing cases studies through tutorials, the curriculum experienced by students may or may not reflect what the curriculum was designed to do (Prideaux, 2003). The following analysis of medical student interviews provides insight into what they experienced through the curriculum, with regard to social class.

What is social class according to second year medical students?

Students were asked how they define social class and although level of income was normally referenced first, other elements of social class were mentioned. For example, one student said: “I don’t know...but if I had to guess I would say it’s a combination of your actual economic class, as well as perhaps your education and your employment and things like, like a combination of things...” Another student drew in the aspects of social class that extend beyond economic resources, hinting at social and cultural aspects: “...to me social class encompasses more than just income, but also education, hobbies, friends, attitudes...,” which is in line with Bourdieu’s habitus where people fit with others based on like-mindedness and comfort (Hannus & Simola, 2010). One student linked social class to other aspects of social location such as gender, sexual orientation and race, which would contribute more to intersectionality than social class, but could be compounding oppressions along with social class: “It’s financial too like where you live your community and also being male/female straight/gay and that kind of thing and a person of colour.” The diversity in characteristics mentioned, with reference to social class, is positive because it allows potential for people to be on a social class spectrum where they may be strong in some areas and possibly lower in others. However, as we’ve seen so far, those who have low income are considered to be low in a multitude of characteristics.

Also, the term social class was used interchangeably with Socio-Economic Status (SES) and Social Determinants of Health (SDH), which each refer differently to an

individual in terms of social circumstances. One student seemed to suggest that social class was a more politically volatile term: "...like when we talk about classes, I find it a...a touchier word...whereas if you say a lower SES, it sounds nicer? Maybe?" Another student spoke of SES but also connected to the ways economic status can affect everyday life, including health:

When I hear social class I think of socioeconomic status so I think of sort of the income bracket that you would fall into or one would fall into I suppose, maybe even the sort of geographical location in which you live and what social supports and social networks exist in that setting to provide support so all those things would tie into I guess what social class you would fall into, but that would be my limited understanding.

SES is a numerical scale used to rank order an individual or household based on income, occupation, and education, and is a "construct that captures various dimensions of social position, including prestige, power, and economic well-being" (Laursen & Tardiff, 2002; Oakes & Rossi, 2003 as cited in Conger, Conger & Martin, 2010). The elements of SES are contained within one's social class and social determinants of health outline aspects of an individual's social circumstances that pose as facilitators of, or barriers to, receiving equitable health care and evaluate more aspects of a person's social class than simply their SES (World Health Organization, 2011). According to renowned social class theorist Pierre Bourdieu, social class includes SES elements as well as characteristics that are not easy to measure, such as interests, beliefs, hobbies, behaviours, and overall "fit" or habitus within a social group (Bourdieu, 1987).

Social class is one of the elements in the social determinants of health, in that health outcomes are affected by economic resources, as well as by factors related both to economics (e.g., housing, employment, nutrition, health care access) and to other less obvious aspects of class (e.g., education, cultural norms and values, social supports).

In the interviews, students sometimes conflated social class and SDH. Nonetheless they also showed some appreciation for the concept of SDH, even when not using the specific terminology. For example, one student said:

...that's the beauty of it... that's what I've enjoyed so much about it is that the social issues are so tightly connected to the medical issues, like they're almost indistinguishable...and vice versa like somebody comes in with these symptoms, 'What's the diagnosis?' 'Why did they get sick?' because they can't afford the medication or because they live next to a garbage dump or whatever those are the kinds of...those are the clear ones [social issues].

The same student went on to raise some fairly nuanced understandings of the relationship between health and social class as a health determinant: "Less clear are

'Why do they have such high stress?' or 'Why do they have such poor eating habits?'" Such comments seem to indicate that education about social class in this curriculum includes at least a basic understanding of how it may operate as a SDH.

Participants discussed social class in terms of extremes of either low or high, avoiding discussions of the middle class entirely: "I guess a very simplistic idea would be working class, like blue collar, white collar, kind of that situation, like people that are manual labourers, physically labourers versus the CEOs and executives of the world." One student both suggested the term social class was dated or inappropriate, and suggested it fit extremes:

Social class sounds to me like this, you know, Victorian England, you got your aristocracy...and then you've got your chimney sweepers...Whereas I find the terms we use now are SES, Socioeconomic Status and then we talk about, like, high or low.

Discussing social class in these extremes can introduce an "Other" who is not "normal" and may be considered deficient, as in the case of lower class individuals. This may also entrench a power dynamic between health care practitioner and patient. In contrast one student spoke of both the lower and upper end of the class spectrum, suggesting the latter group may have things a little easier:

Social class for me I guess would mean more kind of a socio-economic strata in society and I guess I would always look at kind of your haves and your have-nots you know. People who have gotten everything throughout their life ...not necessarily handed to them, but you know they've had to work along the way, but they maybe came by things maybe a little easier than others. Um and then you have the have-nots who really had to work hard to get where they are today.

This student seems to counter a social tendency to speak of class when really meaning only poverty or low income, just one end of a class continuum. Also, the student alludes to the concept of privilege in society, where people higher on the "social class strata" may not have to work as hard as those on the lower class strata. According to the participant's quote above, this is just a fact of life. In society, this is a fact of life where many people in lower class circumstances have social determinants of health that need to be address in order to increase health equity.

According to the participants, when individuals with low income were discussed, they were depicted as also having low education, less professional jobs, less stable family life, and being unable to participate in extra-curricular activities, as well as having other intersecting challenges. This contributes to the construction of the low income Other as existing outside of what is normal and acceptable and implies that the individual needs to be 'helped 'or fixed in order to fit what is deemed 'normal'. Students expressed differing degrees of critical thinking about the way this positioned low income people in their cases and tutorials. For example, one student said, "I think people in that lower socio-economic position probably are less educated, therefore they're less health-

educated, therefore they have less well-paying jobs and it all goes hand-in-hand for me...if you have less money, it's stress around the house." This participant suggests that the ways lower income people were described in the cases and tutorials reflected their own presuppositions, where patients designated as low income in the case studies analyzed in this study, were also described as being deficient in other areas, such as inefficient healthcare education or would not follow doctor's orders by taking medications and/or making it to follow-up appointments.

Others explain further how low income patients were presented within the curriculum: "So and so does this for employment, does not have a drug plan how would you manage that? Or like there is a single mom with two kids and they have difficulty kind of managing work and their children and all that kind of stuff." Another student described a similar approach to cases: "The patient doesn't have a drug plan, it's not covered by Pharmacare (Nova Scotia's public drug plan), 'what do you do at this point?'"

In contrast, one of the students drew a very strong distinction between correlation and causation, seeming to imply that while low income may be linked to other complications and health behaviours, it is not appropriate to see those as characteristic of low income people.

We talked about, in cases, about certain patients who were economically disadvantaged or were involved in substance abuse/misuse and how that can lead to challenges in their lives, in so many areas as we know and a number of different contexts in which I think relate to social class or there's a correlation, not necessarily a causation, but a correlation between that and having a lower social class.

So far, there is a tendency for participants to discuss someone from the lower classes as deficient in a number of ways, consistent with the curriculum analyzed in the previous chapter (e.g., low income and single mother, low income and drug user, low income and less educated), which may further separate the low income Other from the student, and from presumed middle class reality.

One student implicitly stated there is a strong overlap between low income and numerous other social ills:

Let's say it was child abuse, something like that, it would often be a family that was low socio-economic and that perpetuated pretty much through the curriculum...I don't recall of a tutorial where we ever had a, you know, 'Doctor X and Doctor Y have a son who's being assessed for child abuse'...

Finally, some participants spoke about social class as marking differing levels of control over one's personal circumstances. For example, one student said, "I think it's a combination of your home environment, your education, how you feel control over your own life so do you feel you have control over your health, your home environment, your relationships." One participant provided a very concrete example of how poverty can rob people of choice:

In reality, if you're a single parent and you need food for your child and there's employment out there that's illegal, but it's employment and it's going to allow you to provide for your family, I think that most people would do it... You didn't choose to be a criminal, they [you] chose to provide.

By acknowledging that not all people are advantaged by the same choices is all the more reason to integrate a strong curriculum on social determinants of health where students are very clear on how negative social determinants of health create healthcare inequities, but by being able to learn about altering prescriptions and treatments they may be able to help patients succeed some social barriers and enjoy greater health.

Can social class education be utilized by adult learners?

Education research suggests adult learners are performance-centered and need to apply their education (Knowles, 1980). Thus, if education about social class in medical school is delivered in theory only, with no element of practical application, it may miss the mark, especially when students lack real life experience with people from a range of class backgrounds. One student commented,

I think it [social class information] does come up in our cases. I think it gets really hard to really appreciate the situation when it's so fake and so made up within the case. I think that I have learned a lot more about professional [social issues] on electives in the hospital with real patients because it's much easier to empathize and come up with plans when they're in front of you.

Another student thought cases concerning social issues were most powerful when they involved members of the relevant communities, who attended the tutorials to discuss the case studies with the students:

The tutorials and cases I liked best were the ones where they were very real, like our Aboriginal cases we had an Indigenous person from the community in the tutorial group to talk and interact with our group during discussion.

Without real life experience or interactions on which to 'hang' learning from the cases, participants were inclined to devalue the social learning within the actual practice of medicine: "...what are the clinical issues compared to the theoretical ones...?" One student seemed to suggest this devaluation of social information was supported by the clinicians they encounter:

[In the Social Focus cases] you were able to see the, maybe more ideal, ethicist view or lawyer view and then the clinician who says, 'That would be great, if I could spend 5 hours doing that,' but in reality you have 20 minutes and this is maybe more what's likely to happen.

Despite the applied intent of case-based learning, students may not be learning how to apply education about social class in medical performance situations. For example, seeking out a patient's possible negative social determinants of health that may not allow for a generic treatment plan, and how this treatment plan might be restructured to suit the patient's needs, would help students see the practical applicability of learning social class content. Otherwise, students may deem the social class information about

patients is something that “should” be included, and only considered if time permits in the medical encounter.

Foucauldian-inspired Analysis of Participant Interviews

As mentioned in the previous chapter, Governmentality is described by Michel Foucault as the “conduct of conduct” where individuals “act out” or “normalize” certain societal norms and expectations as proscribed, and prescribed, by governing forces, which are able to govern at a distance. Individuals behave in “expected” ways due to unseen pressures that continue to guide them as objects in fulfilling the wishes of governing powers (Ettlinger, 2011). Medical curriculum reveals how neo-liberal governing forces, in this instance operating through the medical school, construct social class, both through how it is discussed and how it is not discussed. This constructed knowledge is reproduced through the formal curriculum, through lectures, by faculty tutors, and by students, as the objects through which the governing forces act through processes that normalize behaviours and circumstances and designate ‘Others’ that are not ‘normal.’

As experienced by the students interviewed, social class education was seen to be governed through three mechanisms: *Individualizing the Social through Health*, as seen in the previous chapter, where the patient is viewed as being responsible for maintaining or obtaining ‘good’ health through making ‘good’ choices to obtain or maintain a ‘healthy’ lifestyle. A second mechanism, *Agency*, also discussed in the previous chapter as a person’s power to act, or in this case the perceived power to act, portrays how the subjects involved have the power (or perceived power) to reinforce or resist social class discourses encoded in the curriculum. In the interviews conducted, students have the opportunity to either reproduce or contest discourses on social class from their formal curriculum, as well as discussing how patients in the curriculum do the same. Thirdly, the *Hegemony of Medical Knowledge* where what is constituted as ‘real’ medical knowledge in the curriculum is biomedical information about a person, whereas social information – including social class details – exists in the margins.

Individualizing the Social through Health

As the case studies individualized the social through health, by placing the responsibility for health on an individual, the participants interviewed reiterated this same position on individualizing the social through health. In the previous chapter, ‘good’ health was shown as expected to be enacted through exercise, making ‘good’ choices, going to the doctor, having the right attitude, and self-directed education, where everyone has the same responsibility and assumed ability to improve their health despite any relevant social class barriers or determinants. When students talked about social class as constituted through their cases, they echoed notions of individual responsibility, choice and ‘lifestyle.’ For example, one student said they explore the medical conditions through the week, then, “on Tuesday [during Social Focus tutorials] you’ll talk about his lifestyle that led him to have all the risk factors to have developed the heart attack.”

Here health outcomes are directly attributed to patient lifestyle. Another student spoke of individual choices, though social class differences were raised implicitly:

If we're talking about heart disease, I can say, 'Oh yeah I remember that patient here and I remember this patient, and their outcomes were different probably because one smoked 2 packs a day for the last 50 years, and that one was a professor at a university and ran a mile a day.

This suggests a basic understanding that the social affects health, but the process is couched in terms of individual choices and thus individual responsibility for outcomes. Without an understanding that social class also shapes individual 'lifestyle', and what may appear from the outside to be bad choices, students seem to be learning that patients are solely to blame for their negative health outcomes.

Participants may believe that poor individual health may result from class-related flawed attitudes or skills. For example, one student noted that social class shapes perceptions of health and health care, suggesting there may be an attitude or mindset inherent in a social class:

Your social class, from earlier on, influences your health and probably before you have any signs of disease, just your mentality...it's very cyclical, so the environment you grow up in really shapes how you see your health and your healthcare experience.

Another student assumed that differences in social class are often accompanied by differences in education levels, and possibly literacy, linking those to health practices and outcomes, as well as education:

Health education [would influence an individual's health, such as] not understanding some of the treatments you are getting or why you're receiving some medication, or even having literacy on your own to [conduct] research around some health issues that you may be confronted with.

This participant seems to link education and literacy with one's health practices and seems to assume a deficit model in which those living on low income are defective in other ways (e.g. education level, literacy). The fact that many people enter the lower social classes through downward class mobility due to illness, disability, divorce or single parenting – and may once have had different education, attitudes or skills – is not taken into consideration.

If patients with low income are presented as deficient in an array of circumstances, this may entrench a negative power dynamic between health practitioner and patient. Some participants reported that in cases where patients were clearly low income, other challenges tended to co-exist: "[Patients] have either a physical disability and they also probably have an intellectual disability... Their health was deteriorating at a younger age, they weren't involved in certain activities, there's more obesity – all things that you generally associate with lower socio-economic classes." Participants reported that low income patients in curricular case studies might be single parents, teen parents, might be "insecurely housed, have hepatitis, they have HIV and they have like every single

risk factor...” Deficit models may construct a low income Other who is understood as vastly different from the participants themselves and potentially making it difficult to appreciate or relate these patients who are described as possibly being vastly different from themselves, creating a greater divide between these two groups.

Participants spoke about the myriad ways income affects opportunities to enact healthy habits: “The poorer you are, the less healthy you are going to be because you can’t afford medication, you can’t afford proper food.” Participants spoke of low income people lacking the resources to access nutritious food, to pay for medications, to research health issues, as well as lacking the time needed to seek health care or engage in ‘normalized’ self-care, such as getting regular exercise, not eating fast-food, and accessing medical coverage. For example, as one participant said about exercise:

It’s really people who can afford to exercise and take the time to exercise that can benefit from that...it’s almost exclusively social factors that influence whether or not they can exercise and then a corollary to that was social factors influence all aspects of health.

Another participant recognized numerous ways health is affected by social class:

We know that higher SES tends to have better health than lower SES...they can afford better groceries, healthier foods, they can afford medications, vacations, nicer houses, there’s less risk of mold...whereas your lower SES...McDonald’s is cheaper than eating out at some fancy restaurant...if you can’t afford 150 bucks a month for health insurance, you’re not paying into that, but at the same time then you get hit with something in your 50s and you’ve got 20 years of high medical bills.

Thus while participants described health and health practices as individual responsibilities, matters of choice and lifestyle, some participants recognized the limitations of that perspective. Participants also spoke of the ways class shapes assumptions, expectations, and available resources to engage in what have been deemed good, moral practices of self-care and health maintenance.

Individual Agency

The previous section discussed how that the dominant discourse in medicine suggests individuals are responsible for obtaining and maintaining good health, regardless of social class constraints. This stance tends to assume everyone has the same ability or power to act, or agency, regardless of social class constraints or social determinants of health.

Through the interviews, participants accounts of social class suggested that they are presented with two conflicting knowledges in education regarding agency in the context of social class and health. On the one hand is the dominant, if sometimes implicit, message that everyone has an equal ability to act in improving their own health by making the right lifestyle choices to produce common health goals. On the other hand,

students were learning about social determinants of health, and how membership in particular (hierarchically organized) social groups affects the ability to enact individual agency. In a single passage, one participant reflected on the tensions between these two positions:

I think that it's [social class] quite central to our health. It impacts not only what health care you're, you have access [to], but also what your day-to-day life is like. So how much sleep you're getting, what kind of foods you're affording and you're choosing to eat and if you can allocate your time to exercise and pay for a gym membership, if you have childcare while you go do that and all those things. But then it also would impact like can you afford the medication that you've been prescribed, or can you go to physio or can you buy that brace that the orthopedics recommended... But also I guess education too, like if you knew, like I think a lot of people just say like health food is good for you, but if you never grew up knowing what is healthy food or if you were presented with a selection of vegetables and you didn't know how to cook them, then how are you expected to do that?

Here the student is mixing both an individualist approach to health and a social determinants of health approach, speaking of both resource barriers and individual agency through lifestyle choices (sleep, exercise at a gym, choosing “good” foods, choosing to do physiotherapy). The tensions between these two ways of thinking about health, mirror the case studies analyzed in the previous chapter.

Teaching opposing information in the formal curriculum (individual agency *versus* social determinants of health) can be frustrating for students. While learning the social determinant of health approach may help them to make sense of the limitations of an individualizing approach, it offers little in terms of ways to reconcile these:

When you're like the naïve first-year medical student, just graduated university, and you're like 'I'm going go out there and teach poor people to exercise or teach poor people how to eat better,' but it's not that simple... You realize quickly that it's so, like, 'Why don't these people take their medications, or why don't they--?' and there's just so much more to the story, and financially again, obviously, but the family dynamics again and who's all involved and what other influences do people have other than their doctor and their health.

Here the participant acknowledges learning about social determinants of health that describe challenges that inhibit some individuals from taking responsibility for their own health in the same way others can, but the participant is also taught that the patient has agency and is in control of, and is responsible for, their health situation. The frustration of not learning how patient agency could be facilitated within the constraints of their social determinants of health is obvious. This frustration may actually diminish the agency of the student, possibly making them feel powerless in their ability to help.

Not only are students apparently not taught how to reconcile individual responsibility for health with a social determinants of health framework – either in theory or in practice – but they are also not taught how social class privilege or disadvantage becomes ingrained in an individual. Thus, agency is believed to be equally held among all in terms of ability to overcome barriers to health and health care. One student spoke about how class is related to education:

I think a lot of that comes down to attitude. If the attitude of your parents is, you know, it's expected that you will graduate high school and after high school you will go to university, and after university you will do your best to get a job– Whereas you might know someone who's, well their parents never graduated high school and never, and you know 'They're doing okay' because that's all you know.

This participant suggests education and employment outcomes are a results of 'good attitudes' and perhaps 'good' parenting. Similarly, another student suggested the effect of class on education is about beliefs and resources: "It's a couple of things, of what you believe you're able to be and where you think the ceiling is set...I think it's also, like, can you afford education, which is expensive. When you're studying you're not working." These characteristics touch on Bourdieu's notions of social capital and habitus, which in the best case scenario, people are in a more privileged situation due to their beliefs and attitudes aligning with those of the dominant societal group, as well as having social and financial resources to succeed in particular educational environments.

It would seem that whether an individual attends and succeeds at university only has to do with having the 'right' attitude and affording tuition. There is no mention of the actual 'fit' of university education for an individual or the class-based culture of higher education. Nor is there any discussion of equally successful life paths. Educational and career success are cast as individual success or failure – if they do not accomplish this, it is due to something they did wrong, specifically lifestyle choices, regardless of possibilities, opportunities or desires.

Individual agency is in tension with barriers, opportunities and constraints for members of all social classes. The flip side of class disadvantage is class privilege, which seems to be addressed less in the medical curriculum analyzed in this study. Nonetheless, as one participant said, "We had lectures on [...] medical students are privileged and come from a position of privilege and just be aware of that when dealing with patients." Participants suggested that teaching about privilege tended to be powerful learning, but was decontextualized, limiting its application. For example, one student described the impact of a session on privilege:

One activity that we were led through in a lecture on cultural competence and this particular activity related to calculating one's privilege and it was a series of questions, which you would score and then at the end of that you would total your score and that would provide you with an indication of how privileged you were... it was neat to see that in our curriculum because I think

that it's definitely something that is valuable for people to think about, so that was something that made an impact.

As interesting as session seemed to be for these participants, the focus was on being aware of one's privilege, in isolation, and not how this privilege may affect one's health or ability to be healthy.

Students did strive to identify ways class privilege would affect people in everyday ways. One student commented, "It would be tough to move upward with no connections." Another suggested even the ability to dream of possible opportunities or trajectories was shaped by expectations and experiences at home and at school. One student reflected on the inter-relationships among economic resources, social networks, and values and attitudes ascribed to class.

Thinking of social class as sort of their network that you surround yourself with, yeah I think it does [influence employment] and I think social class influences in as much as people can wait until they find the job they want. They're not necessarily forced into work right away. They don't put themselves in situations that they need to be that they need money coming in right away and need to take the first job that comes along. People have more flexibility to try out different jobs and if it's something they don't like, try to find a different industry or a different work place.

This student was clearly struggling to articulate how class privilege can subtly shape a career trajectory, simply by providing the freedom from necessity to enable actual choice. The freedom to wait for a desired job, rather than take any job at all for the income, is indeed a privilege. In this instance, choice is framed as a class privilege.

Though formal teaching on privilege may be limited, participants seemed to be trying to use it as a way to challenge dominant discourses of meritocracy, the belief that success in life is due to individual actions and choices, with the accompanying belief that if one person can do it, so can everyone. Above, students were interrogating the notion of choice as being equally available. Some also seemed to reflect on ideas of class-based social capital, and how that may advantage or disadvantage people from differing class backgrounds in employment. One student said:

For example in employment, I think if you come from a higher class family and community, you know how to talk-the-talk. You know how to dress versus if you have someone who didn't grow up in that environment and suddenly they're being interviewed for a job...

Such nuanced – if preliminary – understandings of social class counter the framing of health (and other) outcomes as being the results of individual agency.

While in most of their medical school education students seemed to be learning that people were responsible for self-surveillance, monitoring their own health and improving it through good choices, in the Social Focus cases and tutorials they were learning contradictory theoretical frameworks, ways of thinking about health and access to health

that challenged their existing frameworks. One student reflected on the inaccessibility of a ‘universally accessible’ healthcare system:

I think I learned that it’s much more difficult to access some of the resources that are available than maybe I initially thought. You know growing up you just assume that everyone will be taken care of because it’s Canada or that everyone can get healthcare because we have a public universal healthcare system....and you realize how many papers they need to figure out, fill out, to get whatever funds, and then they don’t actually speak English, so how could they ever fill out the form or they need to bring this form to this office, which is not on a bus route.

Again, this extends a nuanced grasp of class effects on health far beyond simply economic resources, however simply learning about it does not help the student in how this knowledge may be integrated into treatment. As shown in the earlier chapter, the treatment prescribed in all cases included the patient changing lifestyle (unless death or surgery was the treatment), even when challenges or barriers were listed in that patient’s case narrative that could prevent them from doing so.

Participants suggested that the messages about social class gleaned from the medical school curriculum both affirmed and challenged some of what they had known or believed previously. For example, one student suggested that the direct effects of low income on access to health care was not new: “Like, the basics of not being able to afford medication, like something you expected, and then you hear about it that it’s true...the naïve things like the ones that were true, I guess those were reaffirmed.” But the same student suggested there had also been unexpected and disconcerting learning regarding the potential depths of class divides that go far beyond financial resources:

I’ve learned a lot more about um, like, how do I put this? ...Like naïvely coming in I thought everyone trusted doctors and trusted the hospital and wanted to come in if they were sick and weren’t worried about being stigmatized or worried about...just having any kind of social worry about coming into the hospital. And then you learn that people do and like *justifiably* do and even whether, like, maybe not justifiable but whether you agree with it or not, it’s like you have to deal with people like regardless...like if you wanted to help people and hopefully you do, you just have to deal with them as they...you have to accept them as they are even if they are unwilling to take the #1 therapy that you’re offering them that would help them. Like um, so yeah, I guess that was– not that that conflicted with my view, but I’d add that to my view...

There is important insight reflected here regarding the agency enacted by low income people who may choose not to seek formal health care for reasons that make absolute sense to them, and may even be considered “justifiable” by clinicians. This student shows some understanding that goes beyond casting low income people in a deficit model, as lacking the ‘right’ knowledge and attitudes, to reflect on medicine’s own

cultural norms, expectations and assumptions, which may conflict with those held by many people outside the profession.

Marginalization of social class education

Social class content in the curriculum is both structurally and ideologically marginalized in the formal curriculum analyzed in this study, in the shadow of the ‘real’ medical knowledge that is biomedical. Structurally, most social class content is marginalized into the Social Focus section of the curriculum, which is ideologically not considered to be ‘real’ medical content according to participants, in contrast with the biomedical information that mostly makes up the ‘core’ curriculum. As already discussed, two separate types of information are available regarding patients through the medical curriculum analyzed: biomedical information, which in this instance is taught mainly through major Unit cases, and all other information (e.g., social information) that makes the person who they are is taught in the Social Focus cases. As one student said, “pretty well all the social stuff is done in Social Focus.”

In the interviews, some students reflected on the placement of the course content in the curriculum, suggesting that compartmentalization of medical and social content may be problematic:

I think it’s easy just because of the daily routine...like the schedule... to kind of compartmentalize that, but I think after finishing two years and getting ready to go into the full-time clinical setting, I’m very aware of the fact that they do not exist on their own. They overlap on an everyday basis. So yes they are taught in discreet packages, but they’re taught with the message that they overlap and they are one with each other.

Although the message may be that these two discretely taught types of information will overlap in real life, it may be hard and possibly frustrating for the student when they are expected to make this overlap themselves. Students notice the separating of types of content: “That’s one of our classes, on Tuesday we have Social Focus, which is like ethics and professional guidelines and law and like kind of non-medicine stuff that’s very important to medicine...The medical stuff is on the other days.”

Students also suggested the ways the two types of information are taught and assessed differ. The more biomedical content is taught and evaluated in ways that may be more familiar to students who have science backgrounds, thus may appear more legitimate. For example, one participant said:

I think it’s two different ways, two different types of information, two different ways to study, two different ways to explore and explain. The science is pretty cut and dry – answer x or answer y, right. Like on the exams. Whereas the exams with pro-comp they are multiple choice, but they also um they’re dealing with kind of grey area topics that there’s a best answer, but most answers you’d be able to get through an issue, so students do find that a little bit frustrating that we have to study for this pro-comp exam and it seems like

the less you study sometimes, the better you do. It's more kind of a gut reaction thing.

There is a hint here of questioning or dismissing the validity of the type of learning and teaching involved in the Social Focus cases and tutorials. It is seen as involving intuition rather than knowledge, expertise, skill or learning.

If the 'core' curriculum and its largely biomedical content is situated structurally as first priority, and most legitimate, students may be inclined to put in more effort to learn it. As one student said, "There's definitely a tendency for myself to spend more time on the 'core content' than on Social Focus, partly because it's weighted that way in our curriculum." One student reported that learners paid more attention to the "science-y' courses", seeing the Social Focus course as "more relaxed." Another student described that course as "looking at things from a more artsy lens." Yet another student suggested the more socially-oriented information in the Social Focus course was presented less effectively: "I think some of that information is some of the most valuable to us moving forward, but sometimes the way that it's presented, it's not in an engaging way." The structural separation of biomedical and social information in the curriculum, combined with differences in type of teaching and learning can result in the social content being considered non-essential, non-medical information. Students may begin to see the Social Focus social content as an 'add-on' and not an integral part of medical curriculum. Even within the Social Focus course, one student suggested content about social class was somewhat marginal: "There's one explicit pro-comp tutorial on social class, and there was one lecture as well, and then it was sprinkled kind of throughout." As another student said, "It's kind of like it comes up on the side, in the sense that it creeps [up], it rears its head..."

The marginalization of teaching and learning about social class also appears to happen through relegating the relevance of class to particular kinds of topics in the health arena. One participant specifically mentioned nutrition and sexual health:

It also depends on certain topics, if we're talking about sexual health there tends to be a bit more emphasis on social class...sometimes nutrition because I guess social class might affect how your nutrition is, but it's [social class] not necessarily a consistent theme across all units.

Clearly, the Social Focus content, and the social class information included, is not considered as important as the 'core medical curriculum,' and is only considered relevant when health issues are stereotypically associated with people living with low income. Another student suggested social class only really comes up as a kind of afterthought when discussing race.

Where social class appears to most consistently be raised is in teaching about the effect of economic resources on access to health care services. Students reported that in the 'core curriculum' they sometimes addressed questions about drug coverage, and the "affordability" of ancillary services like physiotherapy, massage, occupational therapy

and so on that are billed directly to patients. As one student described it the attention to financial impacts on medical care can be fairly comprehensive:

We learn there's an emphasis placed on making sure that we ask about drug coverage, ask about uh financial circumstances, living circumstances, social support networks because all of these definitely impact you know a number of different aspects for a patient, including response to treatment, adherence, like continuing to take the treatment if it's something that's unpleasant, as well as being able to gain access to the treatment, if it's an expense thing

Yet when students described how they were taught to inquire about financial circumstances within the tutorials, they argued that the methods taught in the Social Focus course were too burdensome, so they had to find ways to cut corners, be more efficient.

One of the lecture talks was on economics and how it impacts the family and one thing that they recommended using with all your patients in your interviews with them is just one question, 'at the end of the month, do you have trouble making ends meet, financially?' So I've found kind of like a quick way to screen for some of the more social class issues, whereas in Social Focus we learn about this 25-question questionnaire that we should be administering to check social class or to check economic class. Like it's not very practical.

This echoes the kind of dismissal discussed previously in this chapter, wherein the social issues – including attention to social class – is marginalized in the name of setting priorities, placing greater value on the biomedical information. As stated by a student, and quoted earlier, they message from clinicians tends to be, “That would be great, if I could spend 5 hours doing that,’ but in reality you have 20 minutes...”

This tendency to dismiss or marginalize attention to the social information concerning the patient extends to the point where some students questioned whether it is relevant to include in the curriculum at all:

I don't know that I'm convinced that it's [social class information] something that needs to be, like, explicitly in the curriculum. I think that students that were taken into the medical school should already have an appreciation and be able to work with people of different social classes and that should be something that you demonstrate way before you're admitted to med school.

Another student suggested that attending to social class in the curriculum in fact entrenches existing social hierarchies, also suggesting perhaps it should not be addressed in teaching and learning: “I think I can see the argument for social class being removed because when it comes down to it, we don't want to be, stratifying people based on social class...” As this participant suggests, it is not positive to reinforce negative stereotypes of those in particular social classes and stratify one group over another, but if discourses around social class were not in terms of deficits or

non-normalcy, but instead as other ways of being as part of a dynamic society, then there may not be a hierarchy.

This treatment of social class content as medically unimportant may arise in part from how has been taught. Students suggest this content is less applied, lacking practical usage, and questioned whether it is even possible to teach about social class:

I think it's impossible to teach in the classroom so I think sort of, I guess— This is all my experience, but when we go to clinic then the social issues are staring you right in the face and you realize that you can't necessarily do what the textbook says, like you need to work with people. Um and that's when social class issues for me come up.

A problem with just letting social class issues “come up” in practice without formal education is that learning must happen ‘on the backs of’ actual people where practice and discussions could have taken place in the classroom. There also seems to be a sense that this kind of content is not teachable, it is solely experiential. One student questioned how you assess social learning:

[It's] really not until you go out there can you understand, like you really have to experience it to understand and work with it to understand. So it's tough to teach in the classroom setting, like what are we going to have a test on social class? Like which, like what person from what social class would do best in this situation? ...It's just something I think you need to learn on the fly sort of...

The notion of “learning on the fly” suggests this information is not considered as important as other information taught in medical school because no one would expect to learn biomedical content “on the fly.” It also denies the validity of numerous disciplines engaged in just this sort of social science teaching and learning.

At the same time, the expertise required to teach social class issues in medicine is contested territory. Some students suggested that having people with relevant PhDs teach this material lacks sufficient clinical experience and application. When the material is taught by tutorial leaders who are clinicians, students can more readily see the relevance.

The PhDs may have certain concentrations in whatever topic comes through and they're advantageous for that, ...they're able to add their perspectives to the rest of the curriculum. I think the physicians at least through anecdotal information are able to at least convey the importance of these topics.

This participant went on to give a concrete example where a tutorial leader who was a surgeon and who worked a lot with a particular disadvantaged community “was able to shed a light on a lot of the issues that come from those communities.” Participants also noted that some of the best learning about social issues arises from tutors and students who ask provocative questions during discussion, that “challenges you to think a little more critically about the answer,” but “it's tough for the school to regulate that or add that into the curriculum because it's so individual and group dependent.” However, if the

tutor noted a particularly stimulating discourse, they could recommend that this be integrated into the case study(ies) for subsequent years.

Students may come to believe that social content does not much matter if: 1) social issues are taught in ways that feel less practically applicable, as it is to identify symptoms and link to a specific disease, 2) if this learning is relegated to only a specific day of the week, 3) social content is only relevant to a narrow set of topics, 4) if the material is inherently less objective and concrete, and 5) if students must work to see the direct application. One participant suggested some of their classmates dismiss the social issues content as almost frivolous:

I know a lot of students find Social Focus kind of, I hate to say it, but they find it kind of annoying, kind of a bird course, kinda something they just have to get done. And the exams are hard because the questions make no sense. Whereas for me it's like, no it's so important and I do fine on the exams because I think it all makes sense. ... Even when we're in our medical cases and sometimes... everyone's like 'Oh this is such a Social Focus-y question!'... I'm like okay, fine, it is an easy question to answer, it's also a very important one.

Thus, at least for some students, the biomedical content constitutes the 'real' curriculum, and the Social Focus content is at best an 'add-on.'

Summary of Interview Analysis

Through these interviews, the experienced medical curriculum, with regard to social class in many ways mirrors the findings regarding the delivered curriculum in the previous chapter, such as the separation of social information from biomedical information, theoretical understandings of social determinants of health without practical application strategies, and that healthcare is the responsibility of the individual through their lifestyle practices, as evaluated by middle or upper class understandings of a healthy lifestyle.

Students understand that there are individuals who experience challenges in their lives due to their social class affiliation, that are not necessarily due to their own actions, which is the premise of the social determinants of health, but there is nothing in their formal curriculum that provides strategies on how to use this information to help the patient improve their health.

Chapter Six: Discussion & Conclusions

"In our attempts to understand the sphere of (adult) education, we cannot avoid the issue of power and social relations" (Kopecky, 2011, p.246). Through a feminist poststructural framework, I have demonstrated how power is exercised in a sample of medical curriculum, through knowledges concerning social class. Individuals and societal institutions, such as educational institutions, become responsible for governing human behavior through self-management in accordance with dominant discourses, and accepting responsibility for social problems (Kopecky, 2011). The ideologies of self-management and being responsible for social problems, in terms of healthcare, can only increase inequities between privileged individuals and those experiencing challenges due to negative, and possibly compounding, social determinants of health. Most likely to suffer from health inequities as a result would be poor, single parents (normally mothers), with a multitude of intersecting determinants.

Adult learners are self-directed and want to apply education they acquire (Merriam, 2001). Learners are motivated to learn based on how knowledge fits with and enacts their identities (Bracher, 2006); whether new knowledge is influenced or challenged by prior experience and learning (Merriam, 2001). As adult learners, medical students may face challenges learning about social class, as their prior knowledge may be selective, due to a tendency for medical students to disproportionately come from upper or middle class sectors of society (Dhalla, 2002; Young et al., 2012). New learning that challenges or contradicts a student's prior knowledge can make learning much more difficult, as prior knowledge must first be let go and this can be an uncomfortable process that may have an impact on the learner's identity (Ambrose, Bridges, DiPietro, Lovett, and Norman 2010; Bracher, 2006). At the same time, medical students who come from lower social class backgrounds may find an identity struggle with fitting in socially to the medical school environment (Beagan, 2005; Mathers & Parry, 2009; Greenhalgh, Seyan & Boynton, 2004).

Given that what is intended in a curriculum, what is actually delivered, and what is experienced by learners may all differ (Prideaux, 2003), this thesis set out to examine both the cases used in undergraduate medical education, and the discourses employed regarding class, as well as student perceptions of social class, having experienced that curriculum. The previous two chapters have analyzed text-based materials from the formal medical curriculum as well as interviews with medical students who have used these materials as part of their formal studies. I conducted this analysis for the purpose of identifying teachings about social class in terms of health and how this education may influence the perceptions of medical students.

Individualising the social in health

As discussed in the literature review, governmentality is a way of understanding the dispersal of normative standards through institutions, such as education and medicine. Dominant discourses about health and responsibility for health circulate through formal and informal mechanisms, exhorting individuals to self-govern to produce themselves as good and healthy citizens (Alvaro, Jackson, Kirk, McHugh, Hughes, Chircop & Lyons, 2010; Weedon, 1987).

Both the case studies and student interviews suggest a dominant discourse in which individuals are responsible for obtaining or maintaining good health, by making good choices, where good health is defined via a normalized, middle class standard that may be difficult or impossible to obtain for anyone not in this social group (Rudman, 2013). Social class circumstances are not taken into consideration when holding individuals responsible for their health, which is extra significant given the recent impetus placed on the social determinants of health in countering health inequities.

The cases materials, both Cardiology and Social Focus cases, suggest that people should reduce their risk of acute and chronic health conditions by living right. The cases, generally, emphasize lifestyle changes either to avoid risk or to treat ill-health, with only an occasional nod to the impossibility of such lifestyle changes for some individuals. Though financial constraints are typically acknowledged, other barriers such as job inflexibility, and the fear of stigma from health professionals are less well addressed.

Interviews with students suggest that the emphasis in the curriculum on individual responsibility is effectively taken up by these adult learners. Recall, one student reported that the Social Focus cases allow students to explore a patient's "lifestyle that led him to have all the risk factors to have developed the heart attack." Students also acknowledged more complex aspects of social class affecting health, speaking of class-based attitudes or "mindsets", as well as ways low income may intersect with numerous other barriers to health such as education, literacy, housing adequacy, social networks. At the same time, they tended to portray low income patients as enmeshed in overwhelmingly complex lives, tending to construct a low-income Other who is understood as vastly different from the students themselves. Nonetheless, the notion of individual responsibility for health remained as students spoke about patients from lower class circumstances not employing the 'correct' help-seeking behaviours, or even resisting the help of health professionals. This exhortation to self-govern, producing the docile subject in accordance to normative standards is central to neoliberal practices of governance (Ettlinger, 2011; Stickney, 2011).

Subjectivities: 'good' and 'bad' patients

When individuals do not conform to norms or expectations for health, the consequence is that they are portrayed, and possibly treated, negatively. Discourses that convey individual responsibility for health, the formal curriculum portrays patients and

physicians in ways that may reiterate power relations that exist in current societal dialogues around health, through characterizations of ‘good’ and ‘bad’ patients and physicians. These governing discourses seek to enforce individual behaviour that is expected in health care encounters, regardless of social class characteristics that may impede or resist these expectations (Hodgson & Standish, 2009; Mayo, 2000).

In the case studies, ‘good patients’ are concerned about their health and take steps to maintain or improve health. All the cases mention patient lifestyle in relation to the health issue concerned, sometimes as a cause of ill-health or as a form of intervention. ‘Good patients’ are those who follow doctors’ orders and choose to follow healthy lifestyles and eating habits, according to standards that are assumed to be known and are not stated explicitly. This is the normalized standard for health that all individuals are exhorted to attain regardless of social class situations or other barriers. In contrast, those who make ‘poor lifestyle choices,’ do not comply with health care advice, or do not take responsibility for their health are constituted as ‘bad patients.’ A bad patient is one who engages in ‘unhealthy’ lifestyle behaviours or who is in poor health due to such behaviours, and the choice not to regulate their actions. Cases mention ‘poor choices’ such as not seeing a physician regularly, discontinuing medications, working when told to rest, and missing health care appointments. They raise ‘lifestyle factors’ such as smoking, drinking alcohol and caffeine, exercise, sleep, diet, and body weight. Notably, these are all ‘choices’ seen as linked to low income and lower social class.

In the interviews students spoke about lower class patients as uneducated and non-compliant, and as having contributed to (if not caused) poor health through lifestyle and diet choices. Although students acknowledged that there may be social class constraints or social factors that negatively affect people’s current health situations, including a lack of ‘proper’ health education, patients are expected to resolve such lacks and barriers themselves.

Agency, objectivity & neutrality

Building on specific training in language use and the construction of truncated patient narratives (Boutin-Foster, Foster & Konopasek, 2008; Taylor, 2003), this study showed that the structure and language used in cases contributes substantially to the reinforcing of a power relationship between physician and patient. The physician is constituted as an objective expert authority, socially and emotionally neutral, while the patient is constituted as more of a ‘mixed bag’ of subjective concerns and relationships (Kenny & Beagan, 2004). The formal cases, especially the Cardiology cases, are often narrated by an invisible third-person narrator, simply reporting objective facts (see de Belder, 2012). There is little or no dialogue, and neither physician nor patient typically speaks. Only in Social Focus cases do patients tend to speak. The language used in cases is objective, formal and fact-based as opposed to explicating the thoughts, emotions, worries or concerns of patient or physician. As Kenny and Beagan (2004) have noted:

There is almost no presence of the patient as person in these cases. Hardly any of them include quotes from the patient... we know little or nothing about the patients' loved ones or their feelings or concerns, about the patient's fears, or even who they are in terms of sociocultural characteristics. (2004, p. 1075)

Kenny and Beagan suggest such cases used as learning tools convey to students "a distorted view of the patient's life in which past and future are, essentially, severed from this medical episode" (2004, p. 1075). They contribute to an existing tendency and desire toward reductionism, stripping away the complex social realities of people's lives through a myopic focus on biomedical facts.

In the cases examined for this analysis, the patient's voice is not rendered important in interactions with physicians, and physicians are portrayed as neutral and all-knowing. Physicians are portrayed as socially neutral relative to patients (see Beagan, 2000). The majority of cases construct an ideal neutral doctor who knows about the patient without needing to collect information or perspectives from the patient directly about their health. This silences the patient's voice and nullifies their relevance as a participant in their own health care. At the same time stereotypes emerge based on the limited social information that is included when discussing the patient, information that normally stems from society-level generalizations of social class (MacLeod, 2011). When assumptions are made based on stereotypical information, important details about the individual patient may be missed.

The Social Focus cases challenge this dominant approach by tending toward language that insists on patients as fully people, and physicians as sometimes having concerns, and engaging in clinical reasoning. The language used in the two types of cases construct very different impressions of the health professional as objective, definitive, authoritative and competent, *versus* receptive, consultative, uncertain, and even tentative at times. In both types of cases, the physician is socially neutral – unmarked by race, ethnicity, social class and so on.

Patients in the cases are identified in terms of social characteristics far more often than are physicians, notably in the Social Focus cases. Even in the Cardiology cases, patients sometimes have a race or ethnicity, and patient occupation is sometimes named, as well as occasionally their living situation. Income is only mentioned for low income patients, usually where the cost of prescriptions is a concern. Mention of social class appeared to serve more to categorize the patient on an SES scale than to learn about social information that may affect health. When patients are identified as lower income, they are depicted as passive, often misguided. They use slang, contrasting sharply with the authority and expertise conveyed through the use of medical terminology by physicians. Even when explicit attention is given to patients being real people, with complex lives that need to be fully taken into account, the language of the cases often renders them objects to be managed rather than agents. In the interviews,

students reported that lower class patients are constructed as being concurrently deficient in a wide range of areas, such as education, literacy, and stress-management, complex 'cases' needing complex management.

This construction of particular subjectivities for low income patients through cases echoes what Macleod found in her examination of medical curriculum where lower class patients had numerous unhealthy habits, were given "joke names" (p.821), blamed for their poor health or death due their lifestyle choices and impulsivity, and were sometimes named by their disease, e.g., alcoholics named "Jack Daniels" (p. 822), all in stark contrast to the middle-class patients who were depicted in a more favourable light (MacLeod, 2011). By characterizing lower class patients as deficient and possibly delinquent, students may develop negative attitudes towards individuals from this social group and interact with them accordingly.

Resistance & tensions

In the interviews, students suggested the dominant messages about social class were partly adopted, and partly resisted. As discussed in the theory chapter, the presence of competing, alternative discourses may prove fruitful to the mounting of resistance to dominant discourses (Johnston, 2014). In this study, student understandings of social class were far more nuanced than was generally shown in the cases, drawing in complex intersecting factors far beyond income such as values and beliefs, employment opportunities, and social and cultural capital. Yet they also described preferring the term 'socioeconomic status' over 'social class' as a politically less-laden term.

Student perceptions of social class tended to the extremes, talking about it as either high or (more often) low, as was demonstrated in the case studies analyzed. The absence of any discussion of a middle class, leaves this as the unexamined, unmarked, invisible underlying 'normal' or normative. It simultaneously constructs the lower-class patients as Other, as needing to work towards becoming normal, in terms of their health and health behaviours. Thus, students tended toward a 'deficit identity', in which lower social class is inherently a problem, a lack, an inadequacy. This echoes one of the concerns raised about cultural competence approaches in medical education, in which culture and 'difference' are only ever posited as attributes of the Other, not of the self (Wear, 2003). In student descriptions, social 'problems' such as domestic abuse and substance abuse were only linked in the cases to low income patients. Social class seems to get reduced to one side of a dualism – the problems of the lower classes. There appears to be virtually no attention to social class privilege, and how that determines the health experiences and outcomes of the middle and upper classes (see also Kumas-Tan et al., 2007). This reinforces a deficit model, in which lower class patients are constituted as problems.

At the same time, it seems the focus of the Social Focus cases and tutorials may provide the beginnings of an alternative discourse that allows some grounds for

resistance to dominant discourse (Weedon, 1987), particularly regarding individual responsibility for health. In the student interviews there were hints or recognition that social and cultural capital play a part in education and employment opportunities, which in turn influence health far more than individual actions and inactions. There were hints that dominant notions of universally equitable access to health care may be limited, if not outright false. There were hints that some students recognized that lower class patients' resistance to health care dictates and lifestyle standards may not be simply 'non-compliance,' but may make sense, be 'justifiable' within the context of their own lives. This suggests a potential resistance to the dominant individualization of responsibility (English & Mayo, 2012; Rudman, 2013).

At the same time, these competing discourses appear to leave the students with unresolved tensions. They learn on the one hand that individuals are solely responsible for their health, that everyone is equally capable of attaining the same level of health through choosing a healthy lifestyle and diet. They learn on the other hand about social determinants of health that are out of an individual's control and may negatively affect health. The individual responsibility discourse seems inherently in tension with understanding the structural determinants that shape ability to enact and idealized 'healthy lifestyle.' MacLeod has noted these competing interests where discourses related to being a competent professional were used in contexts involving mainly biomedical and clinical information and discourses related to how to be a caring health professional were reserved for contexts focusing on social issues (MacLeod, 2011). By separating being competent from being caring, the curriculum gives the impression that one cannot be both at the same time and that there is a specific medical context of when to assume either role.

This contradiction may cause frustration for students who are not able to resolve these two very different discourses and where the dominant social discourse is individual responsabilization for health, social information may be discarded. While the Social Focus cases encourage students to see their patients as people, complete with complex lives, their other cases teach students to strip away extraneous detail not germane to biomedical processes, reducing patients to objects of study (see also Kenny & Beagan, 2004). At the same time, according to the students, their physician tutors also suggest that addressing social determinants of health is unrealistic and overly idealistic. A similar result was found in a different Canadian medical education program, about 15 years earlier (Beagan, 2003).

Application & marginalization

One of the biggest challenges for effectively teaching about social class in medical curricula concerns application of the information. Knowles (1980) has described adult learners as needing to apply the knowledge they learn. Medicine is inherently an applied field, and medical students are adult learners. When information about social class in health and health care is presented but not in ways that can be used, students

may be left wondering how to apply this learning. They learn about the social determinants of health that may negatively affect health situations, but little or nothing about what to do with that information. As Ambrose, Bridges, DiPietro, Lovett, and Norman (2010) suggest, for adult learners to achieve mastery, they need to integrate learning through application. When education emphasizes technical rationality, measurable skills (Gallagher, 2005, p. 139) and competency (Frank, Snell, Cate, *et. al.*, 2010), in ability to demonstrate immediate applicability of learning is possibly fatal. Deleuze and Guattari question whether technical skill, application, competence and mastery are even appropriate for the kind of learning needed:

How have we arrived at a place where competence has seemingly leaked into every area of academic life? It makes perfect sense in areas where we expect trainees to achieve a desired level of skill, information, or technique, but when we apply the same reasoning to habits of thought and feeling beyond the operational and instrumental, we make a wrong turn, drawn by our lust for assessment. (Wear, 2008, p. 625)

The social determinants of health approach emphasizes factors that are out of the patient's control and may negatively influence health (College of Family Physicians of Canada, 2015; World Health Organization, 2011). This may provide an alternative discourse to resist the dominant governing discourse that all individuals are equally responsible for self-management and are failures when they cannot prevent or fix their health problems (Kopecky, 2011). But short of fomenting social class revolution, it leaves students with little direction regarding what to do with that information. This may well lead to feelings of helplessness (see Wear, 2003). When social class information is not taught in a way that can be applied, the student has difficulty using this information and may resort to knowledge that can be applied, specifically resorting to blanket lifestyle changes that the 'responsible' individual needs to abide by to take responsibility for their own wellness.

At the same time this marginalizing of social determinants through lack of direct applicability is coupled with a more structural marginalizing of these components of the curriculum. Recall that in discussing the social determinants of health, one student interviewed said, "That's one of our classes, on Tuesday ... kind of non-medicine stuff that's very important to medicine...The medical stuff is on the other days." In the case analysis, it was noted that cases containing mainly biomedical information are prioritized in the curriculum and developed in ways that support medical professionalism and educational philosophies. This is in comparison to cases that frame patients mainly in terms of social characteristics, which are deemed to be 'add-ons' to medical education. Simply through the structure of the week, social information and medical information are seen as discrete from each other and cases do not teach how to apply social information in terms of treatment or assessment. Learning objectives are separate and distinct.

Students interviewed stated that the Cardiology cases, containing mainly biomedical information, discuss 'real medicine' and the Social Focus cases are experienced as inconvenient additions to the formal curriculum. In student perceptions, these two components of the curriculum convey different bodies and types of knowledge, and employ different learning styles and assessment styles. The teaching and learning in Social Focus course is considered by students to be subjective, 'soft' skills, and some suggested it is impossible (even unnecessary) to teach such social issues. As one student stated, in the context of a pressured, high-stakes curriculum, students may perceive the Social Focus course as "kind of annoying, kind of a bird course". Similarly, Beagan reports that in a course comparable to the Social Focus one students reported "although it was interesting and enlightening to learn about other social groups, other cultures, this had little if anything to do with real clinical practice. The pace of practice, the expectations faced by students, did not leave room for such issues" (2003, p. 612).

This structural marginalization coupled with the lack of applicability of social information may lead to students being frustrated in not knowing what to do with social information even when they do believe it is important. Social information that cannot be applied will likely be disregarded as unusable and irrelevant in a field that is built on application of knowledge. By prioritizing biomedical components and symptoms of people not only dehumanizes individuals, but these teachings further strengthen the power dynamic that exists between the expert physician and passive patient.

In summary, marginalization of social class information as not being as important or medically relevant as is biomedical information, and focusing mainly on those with lower class characteristics in terms of deficient Others, who are likely to be characterized as 'bad' patients because they may not be able to follow doctor's orders or take responsibility for their health according to normalized standards, may lead students to believe that lower class people are doomed to poor health. Coupled with the marginalization of social aspects of the curriculum, and the lack of applicability of the material taught, students may well become frustrated and disillusioned, resorting to those areas where they have confidence in their authority and expertise.

Limitations and recommendations

This study was conducted at a single institution, analyzing part of the second-year medical curriculum and interviews with six students. Including both the case analysis and student interviews enriched the analysis, but limited the amount of breadth possible for each component. But, it was deemed important to analyze both the formal curriculum content as well as how students experienced this curriculum because, as discussed earlier, there may be discrepancies. If a curriculum is deemed effective, but students present a different reality, the curriculum is not, in fact, effective.

The results are not intended to be generalizable, but may present as a starting point for further research on how social class is taught and experienced in order to further improve curriculum. In this case, social class needs to be further integrated into the

'core curriculum' so that it does not seem like add-on content, and needs to be presented in a way that is less theoretical and more practical so that it can be applied in real life situations.

Conclusions

Medical education on social class in the formal curriculum does not present a well-rounded view of society nor does it deliver knowledge on social class in a way that can be applied. Content mainly focuses on those with lower social class who are characterized as the Other, through structure, timing, format, content, and language. This Other who is responsible for obtaining good health and being a good patient, may not be able or willing to fit into these expectations due to social class circumstances or negative social determinants of health. When social class is not taught in an objective way in which students can understand how to use this information in practice, there may be frustration experienced as they try to consolidate conflicting information and expectations. This frustration may result in the dismissal of social class information all together, as they do not see the use for this information.

Adult learners need to be taught the practical application of the knowledge they receive in formal medical curriculum, as medicine is an applied field. Conflicting education may leave learners feeling frustrated and helpless, leaving them feeling personally responsible for not being able to apply this information. If medical students are going to graduate as physicians who embrace "their duty to contribute to efforts to improve the health and well-being of their patients, their communities, and the broader populations they serve", promoting health equity for marginalized populations, (Frank, Snell & Sherbino, 2015, p. 22), they need the most effective education possible regarding social class differences and their effects on health and health care encounters. There is still work to be done in this arena.

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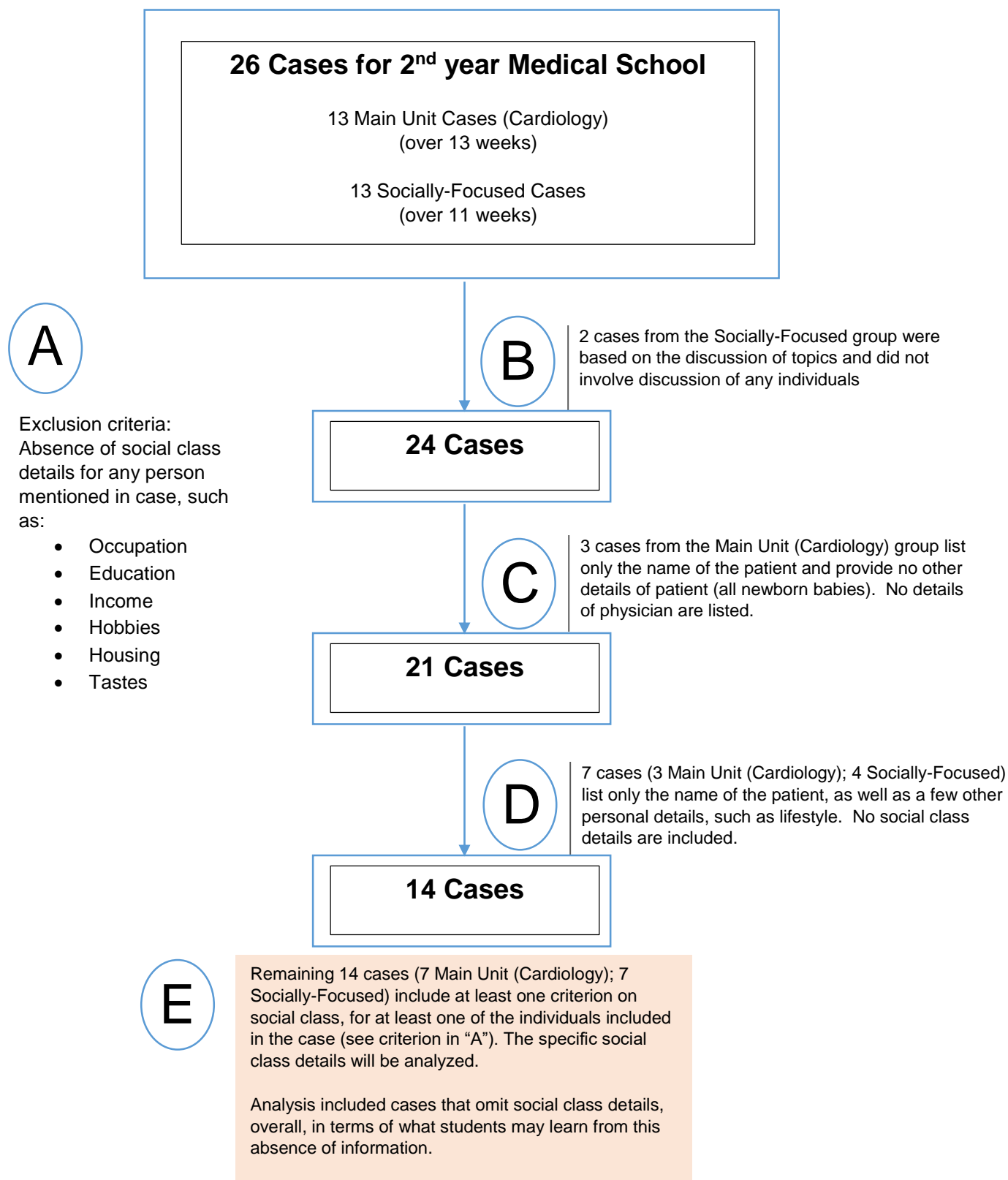
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Appendix 1: Inclusion Criteria for Case Study Selection



2. Is there any information about the social class (or any other representation of culture and diversity) of the physician?

YES NO N/A

Please describe

3. If issues of social class are presented, is this information related to the patients' illness/diagnosis?

YES NO N/A

If yes, please describe

4. If issues of social class are presented, is this the source of difficulty/complication for the physician?

YES NO N/A

Please describe

5. If issues of social class are presented, are stereotypes regarding this particular culture reinforced in the case?

YES NO N/A

Please describe

6. Is the patients' personal life/situation (relationship status, family situation, parental status, etc.) described?

YES NO N/A

Please describe

7. From whose perspective is the case written (i.e. – Dr. Jones sees a patient who feels nauseous... vs. A patient who feels nauseous comes to see Dr. Jones...)?

PHYSICIAN PATIENT OTHER

Please describe

8. Who appears to be the “main character” in the case?

PHYSICIAN PATIENT OTHER

Please describe

9. Is the patients' voice directly represented in the text (i.e. – Does the patient speak in the case?)?

YES NO N/A

Please describe

10. Is the voice of anyone, other than the patient, directly represented in the text (i.e. – Does anyone, other than the patient, speak in the case?)?

YES NO N/A

If yes, who? Please describe

11. Is communication an issue in this case?

YES NO N/A

Please describe

12. Is there any other aspect of this case upon which you'd like to comment?

Please describe

Appendix 3 - Student Recruitment Email

Hi!

Have you ever noticed how people living in poverty are talked about in your curriculum? Have you thought about what medical students learn about wealth and poverty? I am working on a research study on how social class is included in the formal medical school curriculum for my Master's thesis at MSVU and would really appreciate your feedback.

If you are interested in sharing your feedback, I would need about an hour of your time so that we can discuss the topic of social class as it is presented in the medical school curriculum. All content we discuss would be kept confidential and your personal information will be made anonymous. Also, you can stop the interview at any time, for any reason. Also, I can share the results of my research with you and I am also hoping to publish in a peer-reviewed journal in medical education.

You may know me as a staff member of Dalhousie University as the manager of the Integrated Health Research Training Partnership (IHRTTP), but my contact today has nothing to do with my position at Dalhousie University. It is solely for my Master's thesis and your participation is completely voluntary based on your own interest to participate or not.

If you are able to help with this project, please contact me at Terrilyn.chiasson@msvu.ca and we can meet at a day and time that is convenient for you. I will schedule the first 8 students to contact me for interviews and after that will prepare a waiting list in case any volunteers are no longer able to participate.

Thank you in advance, if you are willing to help with my study!
Terrilyn Chiasson, MAEd candidate

Appendix 4 - Student Recruitment Facebook Post

Hi everyone, I am a master's student at Mount Saint Vincent University (although I work at Dal, this request is not at all related to my work) and my research is on how social class is included in the formal medical school curriculum. I would like to talk to students who have just finished their second year of study, since you have finished all required classroom work. This research interview would be no more than 60 minutes and everything you say is completely confidential. We can meet on or off campus, at your convenience, and you can reach me at Terrilyn.chiasson@msvu.ca Thank you in advance, Terrilyn

Appendix 5 – Student Interview Guide

Part I – open-ended questions:

Tell me about yourself:

1. Why did you apply to medical school? (e.g. any family members who are doctors)
2. What did you do before medical school? (e.g. volunteering, undergrad)
3. How's it going so far?

Social Class

1. What does social class mean to you? Can you give examples?

2. Can you comment on how social class might influence:

- Health
- Education
- Employment
- Extra-curricular activities
- Family life

3. Can you comment on your experiences working with people from various social class? (upper, middle, working, lower)

Medical Education

1. Do issues of social class find their way into the curriculum, in your experience? In what contexts? (e.g. Social Focus – do tutors and other classmates talk about social class?)

2. Medical school is busy. How do you balance learning about biomedical and clinical content with more social content?

3. If you could design some curriculum to address social class, what would you do?

4. What was your experience with Social Focus tutorials?

5. Did you learn anything throughout your curriculum, about social class, that conflicted with what you previously thought?

6. Did anything reaffirm what you thought about social class before starting medical school?

Wrap-up

1. Anything else you would to talk about?

Part II – Case study interpretation (short “snippets” of case-studies currently in the medical school curriculum will be presented to the student before asking the following questions)

1. What can you tell me about this patient?

2. What is his or her social class? (if not answered above) Why do you think this?

Appendix 6 – MSVU Ethics Approval



Associate Vice-President (Research)

Certificate of Research Ethics Clearance

Effective Date	April 12, 2016	Expiry Date	April 11, 2017
File #:	2015-094		
Title of project:	What do medical students learn about social class through formal curriculum		
Researcher(s):	Terrilyn Chiasson		
Supervisor (if applicable):	Anna MacLeod		
Co-Investigators:	n/a		
Version :	1		

The University Research Ethics Board (UREB) has reviewed the above named research proposal and confirms that it respects the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* and Mount Saint Vincent University's policies, procedures and guidelines regarding the ethics of research involving human participants. This certificate of research ethics clearance is valid for a period of **one year** from the date of issue.

Researchers are reminded of the following requirements:	
Changes to Protocol	Any changes to approved protocol must be reviewed and approved by the UREB prior to their implementation. Form: REB.FORM.002 Info: REB.SOP.113 Policy: REB.POL.003
Changes to Research Personnel	Any changes to approved persons with access to research data must be reported to the UREB immediately. Form: REB.FORM.002 Info: REB.SOP.113 Policy: REB.POL.003
Annual Renewal	Annual renewals are contingent upon an annual report submitted to the UREB prior to the expiry date as listed above. You may renew up to four times, at which point the file must be closed and a new application submitted for review. Form: REB.FORM.003 Info: REB.SOP.116 Policy: REB.POL.003
Final Report	A final report is due on or before the expiry date. Form: REB.FORM.004 Info: REB.SOP.116 Policy: REB.POL.003
Unanticipated Research Event	Researchers must inform the UREB immediately and submit a report to the UREB within seven (7) working days of the event. Form: REB.FORM.008 Info: REB.SOP.115 Policy: REB.POL.003
Adverse Research Event	Researchers must inform the UREB immediately and submit a report to the UREB within two (2) working days of the event. Form: REB.FORM.007 Info: REB.SOP.114 Policy: REB.POL.003

*For more information: <http://www.msvu.ca/en/home/research/researchethics/policies/default.aspx>

Dr. Daniel Séguin, Chair
University Research Ethics Board

166 Bedford Hwy Halifax Nova Scotia B3M 2J6 Canada
Tel 902 457 6587 • Fax 902 457 2174
msvu.ca

Appendix 8 – Dalhousie University Ethics Approval



**Health Sciences Research Ethics Board
Letter of Approval**

April 05, 2016

Ms Terrilyn Chiasson
Medicine\Dean's Office (Medicine)

Dear Terrilyn,

REB #: 2016-3802
Project Title: What do medical students learn about social class through formal curriculum?

Effective Date: April 05, 2016

Expiry Date: April 05, 2017

The Health Sciences Research Ethics Board has reviewed your application for research involving humans and found the proposed research to be in accordance with the Tri-Council Policy Statement on *Ethical Conduct for Research Involving Humans*. This approval will be in effect for 12 months as indicated above. This approval is subject to the conditions listed below which constitute your on-going responsibilities with respect to the ethical conduct of this research.

Sincerely,

A handwritten signature in cursive script that reads "Catherine Connors".

Catherine Connors, Director

Appendix 9 – Consent Form



CONSENT FORM

Project title: What do medical students learn about social class from the formal curriculum?

Lead researcher: Terrilyn Chiasson, MAEd (candidate), Mount Saint Vincent University, terrilyn.chiasson@msvu.ca

Supervisor: Dr. Anna MacLeod, Associate Professor, Division of Medical Education anna.macleod@dal.ca

Introduction

I invite you to take part in a research study being conducted by me, [Terrilyn Chiasson], a student at Mount Saint Vincent University, as part of my Master's degree in Education. Deciding whether or not to take part in this research is entirely your choice. There will be no impact on your studies if you decide not to participate. The information below tells you about what is involved, what you will be asked to do and about any benefit, risk, inconvenience or discomfort that you might experience.

You should discuss any questions you have about this study with me [Terrilyn Chiasson]. Please ask as many questions as you like. If you have questions later, please contact me: Terrilyn.chiasson@msvu.ca

Purpose and Outline of the Research Study

The purpose of this study is to find out what medical students learn about social class from their formal medical school curriculum. Approximately 8 second-year medical students will be interviewed for their input on what they have learned from their curriculum on the topic of social class. This information will be used to inform the undergraduate medical education in an effort to continually improve the content that is included in the formal curriculum. Also, case studies from the Case-Based Learning section of Cardiology and from the Social Focus unit will be reviewed and analyzed for social class content.

Who Can Take Part in the Research Study

You may participate in this study if you are a second year medical student at Dalhousie University. If more than 8 people volunteer, names will be placed on a wait list in case anyone cancels.

What You Will Be Asked to Do

If you participate in this study, you will be asked to engage in a one-on-one interview for about 60 minutes with questions relating to what you learned about social class from your formal medical school curriculum. I would not need to contact you after we complete our interview together.

Possible Benefits, Risks and Discomforts

Participating in the study will not benefit you directly, but we might learn things that will benefit future medical students by informing the undergraduate medical school curriculum.

The risks associated with this study are minimal. You could become bored or fatigued. However, you will be able to take washroom or stretch breaks as required. You could become distressed reflecting on how social class has been presented in the curriculum. You will always be free to not answer any question, or to cease the interview if you wish. You may also choose to withdraw your interview data from the study.

The expected future use of this data is for use in my master's thesis, journal publications, conference presentations, and also to inform the medical school curriculum.

How your information will be protected:

Privacy: Interviews will take place in a private meeting room at the medical school and no other individuals will hear the content of the discussion.

Confidentiality: I will know who participates, but your interview will be labelled only with an ID number [or pseudonym]. The list linking your contact information and the ID number will be stored only in hard copy in my home office, where it cannot be linked to your interview data. All identifying information will be removed from the transcript of your interview. No demographics (age, gender, background) will be used to identify participants in reports from this study. Consent forms will be stored in a locked filing cabinet in my office, separate from the interview data. The audio recording of your interview will be on a password-protected tablet, then transferred to my password-protected computer through a USB cable. The audio recording will be erased when the transcript is complete.

If I see you at the medical school after the interview, I will not approach you to discuss any details about the study, to protect your privacy. However, if you ever have any

questions, comments, or concerns about the study, following the interview, please do not hesitate to approach me or contact me through email.

Data retention: Information that you provide to me will be kept private. Only I, and possibly a transcriber, will have access to this information. If a transcriber is employed, he or she will not know the names of interviewees. I will describe and share my findings in my Master's thesis, journal articles, conference presentations, with the Associate Dean of Undergraduate Medical Education and the Undergraduate Medical Education Curriculum Committee. I will be very careful to only talk about group results so that no one will be identified. This means that you will not be identified in any way in my reports. Data will be kept for 5 years following publication.

If You Decide to Stop Participating

You are free to leave the study at any time, without any consequences. If you decide to stop participating at any point in the study, you can also decide whether you want any of the information that you have contributed up to that point to be removed or if you will allow me to use that information. You can also decide for up to 1 week if you want me to remove your data. After that time, it will become impossible for me to remove it because analysis will already be well underway for my Master's thesis.

How to Obtain Results

I can provide you with a summary of the results when the study is finished. If you would like to receive a summary of the results of this study, check this box and I will email this summary to you, upon completion of the study.

Questions

I am happy to talk with you about any questions or concerns you may have about your participation in this research study. Please contact me at (902) 494-6834 or Terrilyn.chiasson@msvu.ca at any time with questions, comments, or concerns about the research study.

If you have any ethical concerns about your participation in this research, you may also contact Brenda Gagne at Research Ethics, Mount Saint Vincent University at (902) 457-6350, or email: brenda.gagne@msvu.ca (and reference REB file # 20XX-XXXX)

I have read the explanation about this study. I understand what I am being asked to do and my questions about the study have been answered. I agree to take part in this study. I know that participating is my choice and that I can leave the study at any time.

PARTICIPANT'S SIGNATURE

DATE

RESEARCHER'S SIGNATURE

DATE